USDAN SUMMER CAMP FOR THE ARTS

PROUD PARTNER UJA Federation NEW YORK

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT USDAN

Office Use:

DATE ____________________________

A. To be completed by PARENT or CARETAKER

I request that my child ____________________________, age ________, receive the medication prescribed below at Usdan Center's Health Office. The medication will be furnished to Usdan in a properly labeled original pharmacy container. I understand that a Usdan Center nurse will administer the medication.

SIGNATURE (Parent or Caretaker)__________________________________ **DATE** ______________

ADDRESS____

TELEPHONE (Home)_____________________ (Work)__________________________

B. To be completed by LICENSED HEALTHCARE PROVIDER

I request that my patient, listed below, receive the following medication at Usdan:

NAME OF STUDENT ____

DATE OF BIRTH __________________

DIAGNOSIS ____

NAME OF MEDICATION ____

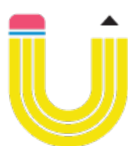
PRESCRIBED DOSAGE, FREQUENCY AND ROUTE OF ADMINISTRATION

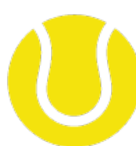
____

____

TIME TO BE TAKEN DURING CAMP HOURS ____

DURATION OF TREATMENT ____





POSSIBLE SIDE EFFECTS AND ADVERSE REACTIONS (IF ANY)

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____

OTHER RECOMMENDATIONS ____

NAME AND TITLE OF LICENSED PRESCRIBER ______________________________

ADDRESS ____

PHONE ________________________

PRESCRIBER'S SIGNATURE ___________________________________

DATE __________

Please note: fill out both parts A and B for each prescription and/or any over-the-counter medication to be dispensed at Usdan. Make additional copies if needed.