USDAN SUMMER CAMP FOR THE ARTS

a beneficiary of UJA Federation of New York Good together.

Office Use:

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

DATE: ________________

A. To be completed by PARENT or GUARDIAN:

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 guardian) ________________________________ **DATE:** __________

ADDRESS: ____

TELEPHONE: (home) _________________________ (work) __________________________

B. To be completed by the LICENSED HEALTH CARE PROVIDER:

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

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):

____

OTHER RECOMMENDATIONS:

____

BUSINESS OFFICE 420 East 79th Street, New York, NY 10075 | Phone: 212-772-6060

CAMP 185 Colonial Springs Road, Wheatley Heights, NY 11798 | Phone: 631-643-7900 | Fax: 631-643-6309

WWW.USDAN.ORG

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.