USDAN SUMMER CAMP FOR THE ARTS

PROUD PARTNER UJA Federation NEW YORK

Office Use:

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

A. To be completed by PARENT or CARETAKER

I request that my child_____, DOB_____ , 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 _____ **DURATION OF TREATMENT** _____

POSSIBLE SIDE EFFECTS AND ADVERSE REACTIONS (IF ANY)

_____

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.