To be completed by Physician ***and*** *Parent/Guardian*

2 I.U. Willets Road
Roslyn, NY. 11576
516 365-7760
Fax 516 869-0964
www.buckleycamp.com

Medication Authorization Form 2018

(ONLY TO BE USED IF MEDICATION WILL BE ADMINISTERED DURING CAMP HOURS AND YOU ARE UNDER 18 YEARS OF AGE)

**Please note that if your child requires benedryl or an epi pen due to an allergy, a *FARE* form must also be completed by both the physician and parent.

If your child requires medication at camp, please contact the camp office/camp nurse by June 1, 2018. Medication with appropriate physician and parent authorization must be received no later than June 25, 2018.

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that my child ________________________ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the original container, properly labeled from the pharmacy with the medication, dosage requirements, doctor's name, and patient's name listed clearly. I understand that the camp nurse or other designated person will administer the medication.

Parent/Guardian Signature: ____ Date: _______________

Print Name of Parent/Guardian: ____

Telephone Number: Home #: ____________________ Work or cell #: ___________________

TO BE COMPLETED BY PHYSICIAN:

I request that my patient, as listed above, receive the following prescription medication(s):

Diagnosis: ____
Medication: ____
Dosage: 1. Amount to be given: ____________________ 2. Time(s) to be given: ___________________________
3. Frequency: As Needed ____ Daily ____ Other _____ 4. Duration of treatment:___________________
5. Method to be taken: ___________________________________
Possible side effects: ____

Diagnosis: ____
Medication: ____
Dosage: 1. Amount to be given: ____________________ 2. Time(s) to be given: ___________________________
3. Frequency: As Needed ____ Daily ____ Other _____ 4. Duration of treatment:___________________
5. Method to be taken: ___________________________________
Possible side effects: ____

Licensed Physician's Signature ______________________________ Physician's Stamp_____________

Physician's Printed Name __________________________________ Date_______________________

Physician's Address ______________________________________ Phone______________________