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

Medication Authorization Form 2019

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

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

**Please note that if your child requires benadryl 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, 2019. Medication with appropriate physician and parent authorization must be received no later than June 25, 2019.

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_____