

## 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** \_\_\_\_\_

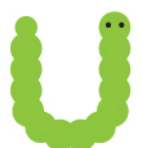
**NAME OF MEDICATION** \_\_\_\_\_

**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.