DATE

BADGER DAY CAMP

Parent and Physician Authorization Form

119 Rockland Ave, Larchmont, New York 10538 • 914.834.1084 • info@badgerdaycamp.com

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician.

_____

Signature (Parent or Guardian)

_____

Telephone: Home Work Date

B. To be completed physician

I request that my patient, as listed above, receive the following medication:

_____

Medication:

_____

Diagnosis:

_____

Dosage and Route of Medication

_____

Frequency/Time to be given:

_____

If prn, for what symptoms

_____

Desired Action

_____

Possible Side Effects

_____

Duration of Treatment

_____ _____

Physicians Signature Date

_____ _____

Physician's Name (print) Phone

_____ _____

C. Nurse's Signature (To be signed by Camp Nurse) Date