The Dobbs Ferry Recreation Department

MEDICATION AUTHORIZATION

If your child is required to take any medication **DURING CAMP HOURS.**

This form **MUST BE COMPLETED BY BOTH PARENT AND PHYSICIAN.**

Date _____ Parent's Signature _____

Child's name _____ is to receive (Name of Medication)

_____ for _____(Diagnosis of

Condition.) Dosage and frequency: _____

The possible side effects are: _____

_____

_____

Signature of Physician: _____

Address: _____

Phone _____ Date: _____