

# The Dobbs Ferry Recreation Department

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## 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: \_\_\_\_\_