UNION COUNTY YOUTH PROGRAM(S) – PHYSICIAN'S AUTHORIZATION FORM FOR THE ADMINISTRATION OF MEDICATION(S)

Child's Name:______________________________ **Date of Birth:**____________________________

Any Known Allergy (Food or Drug): ____

____

In order to protect the health of_________________________, it is necessary for him/her to have the following medication(s) during program hours:

NAME OF MEDICATION:____

____

MEDICATION EXPIRATION DATE:____

DOSAGE:____

TIME to be administered:____

PURPOSE of medication:____

List any possible SIDE EFFECTS:____

____

____

The child is authorized to self-administer the above prescribed medication during program hours:

☐ Yes ☐ No

Signature of Physician:____________________________________ Date:_____________________

Print Physician's Name:___________________________________ Phone:___________________

Address:____

Physician's Stamp:____

Please Return To:

Union County Parks & Recreation

Watchung Stable ♦ 1160 Summit Ln ♦ Mountainside ♦ New Jersey 07092-1409

908 789 3665 ♦ www.ucnj.org/parks-recreation/**watchung-stable**

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