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

PHYSICIAN NAME:_____

PHYSICIAN ADDRESS:_____

PHYSICIAN PHONE NUMBER:_____

Child's Name:_____ **Date of Birth:**_____

Any Known Allergy (Food or Drug): _____

_____

NAME OF MEDICATION:_____

_____

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

Additional Instructions:_____

_____

SIGNATURE OF PHYSICIAN:_____

PRINT PHYSICIAN'S NAME:_____

PHYSICIAN'S STAMP:_____

Please Return To:
Union County Parks & Recreation
Watchung Stable♦ 1160 Summit Lane ♦ Mountainside ♦ New Jersey 07092-1409
908 789 3665 ♦ www.ucnj.org/parks-recreation/watchung-stable

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