

**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

Trailside Nature & Science Center ♦ 452 New Providence Road ♦ Mountainside ♦ New Jersey 07092-1409
908 789 3670 ♦ www.ucnj.org/parks-recreation/trailside-nature-science-center

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