

# Joel Ross Tennis/Golf & Sports Camp

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## PRESCRIBED MEDICATION AUTHORIZATION FORM

**Part 1 must be signed by physician**

**Part 2 must be signed by parent**

### 1. AUTHORIZATION BY PHYSICIAN:

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Condition for which drug is being administered during camp hours \_\_\_\_\_

DRUG: Name of Drug, Dose and Method of Administration \_\_\_\_\_

Times of Administration: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Medication shall be administered from \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, plan for management \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_

Allergies, reaction to, or negative interaction with food or drugs? If YES, list \_\_\_\_\_

The authorized prescriber's (Doctor) or Dentist's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHYSICIAN'S PRINTED NAME** \_\_\_\_\_

### 2. AUTHORIZATION BY PARENT for the administration of the above medication:

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child \_\_\_\_\_, be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medications shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian \_\_\_\_\_ **Signature** \_\_\_\_\_

Relationship to child \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_