

Pelham Recreation Department

20 Fifth Avenue

Pelham, NY 10803

PARENT AND PRESCRIBERS AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN PELHAM RECREATION PROGRAMS

SELF-MEDICATION RELEASE FORM

Date: _____

Child's Name: _____ has been instructed in the proper use of the

Following medication procedures: _____

We (physicians signature) _____

and (Parent/Guardian's signature) _____

request that (child's name) _____ has permission to administer their
own medication.

Medication will be handed to your child by either the Program Director or Assistant Director.
Your child will take the medication in his/her presence.

If your child is unable to do so, our Program Director or Assistant Director will administer it in
accordance with the parent and healthcare provider's.

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN PELHAM RECREATION ACTIVITIES

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PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN PELHAM RECREATION ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by the Private Healthcare Provider:

I request that my patient, a listed below, receive the following medication:

Name of child _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment _____

Possible Side Effects and Adverse Reactions (if any): _____

Healthcare Provider's Signature _____ Date _____

Address: _____ Phone _____

- Medication must be in original pharmacy labeled container with specific orders and name of medication.
- Medication and refills must be brought to the recreation office by parent, guardian or responsible adult