

**Pelham Recreation Department**

**20 Fifth Ave**

**Pelham, NY 10803**

**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: \_\_\_\_\_

<b>MEDICATION</b>	<b>DOSAGE</b>	<b>FREQUENCY/TIME TO BE TAKEN</b>	<b>ROUTE OF ADMINISTRATION</b>

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

