PHYSICIAN'S AUTHORIZATION

This release is valid for up to three (3) years from the date of signature unless otherwise noted.

Patient's Name: ___________________________________ Date of Birth: ______________

1. Is this patient diagnosed with a developmental disability?
   (Please be Specific) ____

2. Does this patient have any physical disabilities related to:

	Disability	Extent
Ambulation	______________________________________	__________________________
Hearing	______________________________________	__________________________
Vision	______________________________________	__________________________
Speech	______________________________________	__________________________
Balance &	______________________________________	__________________________
Coordination	______________________________________	__________________________

3. Patient History:
   a. Chronic diseases: heart _________ diabetes_________ other ____________
      Describe: ____
      Resulting limitations: ____
   b. Seizures ________________ degree ________________ frequency _____________
      Known antecedent____
   c. Frequent colds _________________________ frequency _______________________
   d. Ear infections _________________________ frequency _______________________
   e. Allergies (food restrictions) ____
   f. Allergies (Medications) ____
   g. Hepatitis ________________________ Type ______________________________

4. Has this patient benefited from all recommended immunizations:________
   a. Diphtheria/Tetanus Toxoid (4 doses) Dates: _________,________,________,________
   b. Oral Polio Vaccine (3 or more doses) Dates: _________,________,________,________
   c. MMR Vaccine (2 doses) Dates: _____________,____________
   d. Hepatitis B (Hep B) (3 doses) Dates: _________, _________, _________
   e. Haemophilus influenza type B (Hib) Date: _________
   f. Varicella (Chicken Pox) Date: _________

   If no, what immunizations are lacking:____
   ____

5. Does this patient take medication daily? ____

   If yes, please fill out the next page

6. I recommend this patient for:

   a. _______ **Full** participation in North East Westchester Special Recreation programs **including swim**
   b. _______ **Participation** in North East Westchester Special Recreation
      programs with the following limitations:__________________________________
      ____
   c. _______ **No participation** in any North East Westchester Special Recreation programs due to:
      ____

7. Signature of Physician: ____ Date: ____________

   Address: ____ Phone #: ______________

NORTH EAST WESTCHESTER SPECIAL RECREATION, INC.
63 Bradhurst Ave., Hawthorne, New York 10532
914-347-4409 Fax 914-347-5054

Physician's /Parent's authorization for medication administration at North East Westchester Special Recreation Programs

I authorize my patient, as named below, receive the following medication:

Name____DOB____________________

Medication_____________________________Dosage_______________Time_______________

Medication_____________________________Dosage_______________Time_______________

Medication_____________________________Dosage_______________Time_______________

Medication_____________________________Dosage_______________Time_______________

Is this patient on any controlled medications? _________Yes __________No

Are there any specific dosing instructions?____

Nurses are not permitted to administer any over the counter medications without a doctor's order. Tylenol, Motrin, creams, ointments, MUST be ordered and the order must include: Name of the medication, dosage (in Milligrams for oral meds) reason/indication for medication, and the interval between doses.

____
____
____
____
____

Physician's Signature____Date_______________

NYS DEA Reg. #__________________________Address:____

PARENT AUTHORIZATION

I, ______________________________________, give my permission for the North East Health Director and

delegated staff to administer medication to my child,____.

Signature- Parent/Guardian ____ Date_______________