North East Westchester Special Recreation, Inc.
63 Bradhurst Avenue
Hawthorne, NY 10532
Phone: 914-347-4409 | Fax: 914-347-5054
www.northeastspecialrec.org

Physician Authorization Form

(Release if valid for 3 years from date of signature unless otherwise noted)

Participant Information		
Last Name	First Name	
Birthdate	Age	Sex

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

   ____

   ____

   ____

2. Does this patient have any physical disabilities related to:
   - ☐ Ambulation: ______________________________
   - ☐ Hearing: ______________________________
   - ☐ Vision: ______________________________
   - ☐ Speech: ______________________________
   - ☐ Balance & Coordinate: ______________________________
   - ☐ Other: ______________________________

3. Patient History:
   - ☐ Chronic Diseases: ☐ Heart ☐ Diabetes ☐ Other: ______________

     ____

   Limitations: ______________________________
   - ☐ Seizure: ☐ Grand Mal ☐ Petite Mal Frequency: ______________
   - ☐ Frequent Colds: ______________ Frequency: ______________
   - ☐ Ear Infections: ______________ Frequency: ______________
   - ☐ Food Allergies: ______________________________
   - ☐ Medical Allergies: ______________________________

☐ Hepatitis: ______________________________ Type: ______________________________

5. Does this patient take medication daily?
   ☐ Yes *(please fill out Authorization for Medication Administration Form)*
   ☐ No

6. I recommend this patient for:
   ☐ **Full Participation** in North East Westchester Special Recreation Programs, including Swim

   ☐ **Participation** in North East Westchester Special Recreation Programs with the following limitations: ____

   ____

   ☐ **No Participation** in any North East Westchester Special Recreation Programs due to: ________

   ____

   ____

Physician's Signature: ________________________________ Phone: ________________________

Physician's Address: ________________________________ Date: ________________________

____

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Physician's Authorization for Medication Administration at North East Westchester Special Recreation Programs

(Please include a copy of patients most recent immunization records)

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

Participant Information		
Last Name	First Name	
Birthdate	Age	Sex

Medication Information		
Medication	**Dosage**	**Time**

Is the patient on any controlled medications? ☐ Yes ☐ No

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 med, and the interval between doses.

NYS DEA Registration Number: ____

Address: ____

Physician's Signature: ____________________________ Date: ____________________

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Parent Authorization Form

Parent/Guardian Information		
First Name	Last Name	Relationship
Phone	Email	
Address		
City	State	Zip

I, ______________________________, give my permission for the North East Westchester Special Recreation delegated staff to administer medication outlined by my physician to my child, ___________________________.

Along with this authorization, I will also be providing the most recent copy of my child's immunization records.

Parent/Guardian Signature: __________________________________ Date: _______________

Physician's Signature: _______________________________________ Date: _______________