



North East Westchester Special Recreation, Inc.

63 Bradhurst Avenue
Hawthorne, NY 10532

Phone: 914-347-4409 | Fax: 914-347-5054

www.northeastpecialrec.org

Group Home 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
Group Home		

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: _____



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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		
Last Name	First 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: _____