AUTHORIZATION FOR DISPENSING MEDICATION
IN SCHOOL OR CAMP

PARENT/GUARDIAN:

I request that my child _____ receive the medication as directed in the form below and prescribed by

_____
Physician's Name

_____
Signature of Parent/Guardian

Telephone No. _____Date_____

PHYSICIAN:

I request that my patient _____receive the following medication:

Name of Medication: Benadryl
Diagnosis: Allergy to _____
Prescribed Dosage: _____
Time to be taken during school or camp hours: As needed, every 6 hrs.
Expected duration of treatment: As needed, through the school year or camp session
Possible side effects and adverse reactions: Sleepiness or hyperactivity, dry mouth
Other recommendations: If ongoing allergic reaction not responding promptly to Benadryl, must be seen right away by health care provider.

Print Name: _____ **Tel. No:** 617-323-4440

Signature: _____ **Date:**_____