Cooperstown All Star Village

Baseball Camp Medication Sheet

Form Must Be Completed by March 1st

INDIVIDUAL ORDERS FOR:

Name______________________________ **DOB**________________ **Weight**______________

Team name _________________________ Coach____________________________________

Date attending CASV ____

Prescription Medications (MUST complete with patient's current regimen for both scheduled and PRN medications Use 2nd page if needed). Physician's signature is required.

Drug	Route	Dosage	Schedule and Indications	Comments

Camper's Healthcare Provider (MD, NP, PA) Name ______________________________ **Phone**___________________

Address _____________________________________ **License #**________________________________

Physicians Signature___________________________________ **Date**____________________________________

If prescription medications are not needed a physician's signature is not required

If PRESCRIPTION MEDS are NOT needed please check here and sign below: ________________

Parent Signature ____ **Date:**_________________________