Gomathi Pediatrics PLLC
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New City, New York 10956
Tel: 845-634-8911
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MEDICAL ORDERS FOR SCHOOL OR CAMP

TO BE COMPLETED BY PARENT:

I wish my child _____ to have the medication prescribed by Dr._____ on _____.

_____
Parent's Signature

TO BE COMPLETED BY PHYSICIAN:

Name _____ Date _____

Medication _____

Frequency & Dosage _____

Side Effects to Be Observed, If Any _____

_____

Approximate Duration of Treatment _____

Condition Being Treated _____

_____ _____
Date Physician's Signature