



Cooperstown All Star Village

Baseball Camp Medication Sheet

Form Must Be Completed and Mailed by March 1st to:
Cooperstown All Star Village
PO Box 670 Cooperstown, NY 13326



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: _____