RANDOLPH TOWNSHIP SCHOOLS
RANDOLPH, NEW JERSEY

Parent Authorization for Medication to be Taken During School Hours

Student's Name ______________________________ **Sex** _______ **Date of Birth** ______________

School _________________ **Teacher** _____________________ **Grade** ______ **Room** _______

Physician's Name **Address** **Telephone**

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I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

____ _____________________________
Parent/Guardian Signature **Date**

____ _________________ ___________________
Parent/Guardian's Name (please print) **Home Phone** **Emergency Phone**

Physician Authorization for Medications to be Taken During School Hours

TYPE OF ILLNESS: ____

MEDICATION/DOSAGE: ____

TIMES TO BE ADMINISTERED: ____

If medication is "when needed", describe indications:

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HOW SOON CAN DOSAGE BE REPEATED? ____

POSSIBLE SIDE EFFECTS: ____

LENGTH OF TIME MEDICATION IS TO BE CONTINUED: __________________________________

____ __________________________
Physician's Signature **Date**

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Physician's Name (please print)

5-17A