

**RANDOLPH TOWNSHIP SCHOOLS
RANDOLPH, NEW JERSEY**

**Parent Authorization for Medication to be Taken During School Hours
and/or Field Trips or School-Sponsored Events/Activities**

Student's Name _____ Sex _____ Date of Birth _____

School _____ Teacher _____ Grade _____ Room _____

Physician's Name _____ Address _____ Telephone _____

I request that my child be assisted in taking the medicine(s) described below during school hours and/or field trips or school-sponsored events/activities by authorized persons.

Parent/Guardian's Signature _____ **Date** _____

Parent/Guardian's Name (please print) _____ **Home Phone** _____ **Emergency Phone** _____

**Physician Certification for Medication to be Taken During School Hours
and/or Field Trips or School-Sponsored Events/Activities**

TYPE OF ILLNESS: _____

MEDICATION/DOSAGE: _____

TIMES TO BE ADMINISTERED: _____

If medication is "**when needed**", describe indications:

HOW SOON CAN DOSAGE BE REPEATED? _____

POSSIBLE SIDE EFFECTS: _____

LENGTH OF TIME MEDICATION IS TO BE CONTINUED: _____

Physician's Signature _____ **Date** _____

Physician's Name (please print)