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)

_____
Physician Stamp