

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 \_\_\_\_\_ Date of Birth \_\_\_\_\_

School: Randolph High School Club: Speech and Debate Grade \_\_\_\_\_

**Step 1:** ANY medication (including OTC such as Advil, Benadryl, etc.) must be included on this form.

\_\_\_\_\_ My child does not take any medication. Signature \_\_\_\_\_

\_\_\_\_\_ My child takes medication. → Move on to Step 2

**Step 2:** I request that my child be assisted in taking the medication(s) described below during school hours and/or field trips or school sponsored events/activities by authorized persons.

**Note:** EACH MEDICATION requires its own form.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (please print)

\_\_\_\_\_  
Phone Number

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

*This section is to be filled out by the child's physician.*

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Physician Address

TYPE OF ILLNESS:

MEDICATION/DOSAGE:

TIMES TO BE ADMINISTERED:

If medication is "when needed," describe indications:

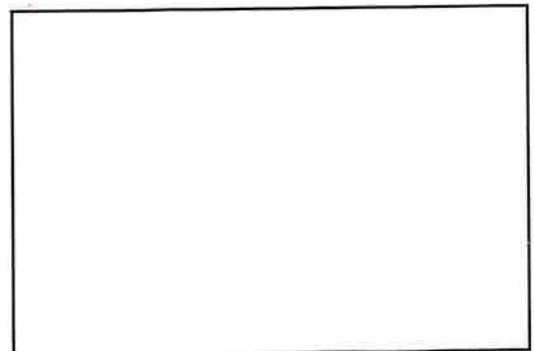
HOW SOON CAN DOSAGE BE REPEATED?

POSSIBLE SIDE EFFECTS:

LENGTH OF TIME THE MEDICATION IS TO BE CONTINUED:

\_\_\_\_\_  
Physician Signature / Date

\_\_\_\_\_  
Physician Name (please print)



Physician Stamp