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