

NAME OF STUDENT: \_\_\_\_\_  
HOMEROOM: \_\_\_\_\_

**RIDGEWOOD PUBLIC SCHOOLS  
SCHOOL HEALTH SERVICES  
AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL  
HOURS AND ON  
AUTHORIZED FIELD TRIPS**

1. Parent Authorization (to be completed by parent)

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School

Child's Name \_\_\_\_\_  
Last First Sex Date of Birth

I request that my child be assisted in taking the medicine(s) described below at school/camp and on school field trips by authorized persons or be permitted to medicate herself/himself as also authorized by me and my physician (see below). I relieve the Board of Education and its employees of any and all liability, which may result from the administration of medication to my child or from self-administration when certified by the physician.

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Date Parent/Guardian Signature Home Phone Emergency Phone

2. Physician Authorization (to be completed by physician)

Diagnosis for or reason for which medication is given: \_\_\_\_\_

Name of medicine: \_\_\_\_\_

Form: \_\_\_\_\_

Dose: \_\_\_\_\_

Time; \_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_

Is child capable and instructed in self-administration? Yes \_\_\_\_\_ No \_\_\_\_\_

Potentially life-threatening condition for self-administration: \_\_\_\_\_

List significant side effect: \_\_\_\_\_

Ramifications of failure to medicate: \_\_\_\_\_

Length of time this treatment is recommended: \_\_\_\_\_

Other information: \_\_\_\_\_

Emergency Intervention Protocol: (Epi-Pen, inhaler, insulin, glucagons, etc.)

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Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Please print: Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

***\*Please be sure to read the information the other side of this sheet.***

**RIDGEWOOD PUBLIC SCHOOL  
RIDGEWOOD, NEW JERSEY**

**SCHOOL HEALTH SERVICES  
ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

The administration of prescribed medication to a student during school hours will be permitted when failure to take such medication would jeopardize the health of the student or the student would not be able to attend school if the medication were not administered during school hours. The school nurse or parent may administer medication during school hours with permission for self-administration for life threatening medical conditions. The policy for the administration of medication during school hours is as follows.

1. A written request must be completed and returned to the school nurse for the administration of medication authorized by the physician as requested by parent/guardian ( I. Parent/Guardian Authorization) relieving the Board of Education and its employees of liability for administration of medication.
2. A written request must be completed and returned to the school nurse by the prescribing physician detailing the name of medication, diagnosis, dosage, form time of administration, duration of treatment, side effects and ramifications of failure to medication( II. Physician's Authorization).
3. Permission may be granted to a student for self-administration of medication for asthma or other potentially life-threatening illnesses (i.e.: Inhalers, Epi-pens, Glucagon, etc.) provide the parent/guardian and physician authorizations are completed, including written certification regarding the student's condition and that the student is capable and has been instructed in self-administration of the medication.
4. The district shall incur no liability as a result of an injury arising from the self-administration of medication by the student.
5. The medication must be brought to the school nurse in a container properly labeled with physician's name, child's name, drug, expiration date, and dose schedule by prescribing physician or pharmacy. The nurse may verify prescribed medication with the physician.
6. The school physician may review the medication orders of the private physician.
7. Parent/guardian must contact the school nurse regarding field trips and/or individual student health/medical conditions that may necessitate immediate medical intervention, including the administration of medication (i.e. Epi-Pen, Inhaler, Insulin, Glucagons, etc.) The physician must complete the appropriate section of the physician's authorization for administration of medication (III Physician's authorization)

***\*Please be sure complete the information on the other side of this sheet.***