

RIDGEWOOD PUBLIC SCHOOLS

Ridgewood, New Jersey

School Health Services

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING:
RIDGEWOOD HIGH SCHOOL BAND PROGRAM TRIP TO CALIFORNIA
FEBRUARY 7 – 12, 2020
(TO BE COMPLETED BY A PARENT/GUARDIAN)

I. Parent Authorization (to be completed by parents.)

Child's Name _____
Last First Sex Date of Birth

I request that my child be assisted in taking the medicine(s) described below during the RHS Band Program trip to California by authorized persons or be permitted to medicate himself/herself as also authorized by me and my physician (see below.) I relieve the Ridgewood Board of Education and its employees of any and all liability that may result from the administration of medication to my child or from self-administration when certified by the physician.

Date	Parent/Guardian Signature	Home Phone	Emergency Phone
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II. PHYSICIAN AUTHORIZATION (to be completed by physician)

Diagnosis for or reason for which medication is given _____

Name of Medication _____

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 effects: _____

Ramifications of failure to medicate: _____

Length of time this treatment is recommended: _____

Other information: _____

*Emergency Intervention Protocol:
(Epipen, inhaler, insulin, glucagon, etc.) _____

Date: _____ Physician's Signature _____

Physician's Name _____

Address _____

Telephone# _____