RINGWOOD PUBLIC SCHOOLS
Board of Education Office • 121 Carletondale Road • Ringwood , New Jersey 07456

Phone: 973-962-7028 ex. 20 • *Fax: 973-962-9211*

Medication Form

From the Office of the School Nurse

Parent or Guardian to complete this portion

NAME OF STUDENT: ____

SCHOOL: ______________________ GRADE: ______________

- I understand that I must supply the school with all equipment/supplies needed to administer the medication.
- I understand that all medications must be in the original prescription container and labeled appropriately.
- I understand that all medications must be brought to school by a parent or guardian in schools K-5.
- I authorize the medication described below to be administered as directed by my child's physician.

____ ______________
Signature of Parent/Guardian Date

Physician to complete this portion

1. Medication: ____
2. Dosage: ____
3. Time of Administering: ____
4. Duration: ____
5. Purpose of Medication: ____
6. Possible Side Effects: ____
7. Is Child able to self-medicate when on a class trip: yes ________ no __________

______________ ______________________ ______________
Physician's Stamp Physician's Signature Date