Ringwood Public Schools
Ringwood, New Jersey 07456
Office of the School Nurse

For Completion by Parent/Guardian

Name of Student________________________________ Grade____________

School__________________________________Home Phone______________

- 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*____

For Completion by Physician

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_______________

*Physician's Signature*____________________________________

*Date*____