NEW JERSEY STATE POLICE

Trooper Youth Week - Medical/Emergency Information

(**To be completed by parent/guardian.** Place N/A when information is not applicable. Print all information)

____
(Last Name, First Name of Trooper Youth)

A. Explain any existing medical conditions the Trooper Youth candidate may have:

1.____

2.____

B. List any medications (both over-the-counter and prescription) to be taken during the week.

MEDICATION:	DOSAGE:	CONDITION PRESCRIBED FOR:	
SIDE EFFECTS:	PRESCRIBING PHYSICIAN:		PHYSICIAN'S TELEPHONE:
MEDICATION:	DOSAGE:	CONDITION PRESCRIBED FOR:	
SIDE EFFECTS:	PRESCRIBING PHYSICIAN:		PHYSICIAN'S TELEPHONE:

** add additional information on the back of this form if necessary.*

C. List/explain any allergies or nutritional requirements.

1.____

2.____

Prior to Trooper Youth's arrival, all medications are to be labeled and stored in their original container or prescription container, as applicable, and in accordance with manufacturer instructions.

The Trooper Youth will provide **four full days' supply of medication only**.

FAILURE TO COMPLY WITH THIS WILL PREVENT THE CANDIDATE FROM PARTICIPATING IN THE TROOPER YOUTH PROGRAM.

In Case of Emergency, contact:____

Relationship: ____________________________ 24 Hour Phone #: (____) ____________________

I, the Parent/Guardian, grant the New Jersey State Police Academy Staff permission to seek/provide medical attention in case of emergency, should I not be able to be contacted.

______________________________	______________________________
Physician Name	Physician Telephone Number
______________________________	______________________________
Parent/Guardian Print Name	Parent/Guardian Signature