OAKLAND CHRISTIAN SCHOOL
Authorization for Administration of Medications for
Overnight School Sponsored Trips

Dear Parent and Physician:
It is the policy of Oakland Christian School to have written authorization when we are involved with a student taking medications while attending a school retreat/trip.

This authorization is valid for the dates of _____.
Name of Trip: _____.

Student's Name: _____ Date of Birth _____
(please print) (grade)

School-Provided (Stock) Medications are available for students who may need relief from minor pain/discomfort while away from home. They will be administered by the nurse or adult chaperone after assessment of the student's need. The stock medications include: Tylenol, Advil, Aleve, Benadryl, Tums, cough drops, Neosporin, hydrocortisone cream, saline eye drops.
Please sign here if you authorize school personnel to administer these stock medications based on your student's request for pain relief and the appropriate dosing for current weight.
Parent Signature: _____ Date: _____

Parent-Provided Medications:
All medications *must be dropped off to school personnel by a parent at registration. Please allow time for the check-in process. NO medications are allowed in the student's possession at any time, other than life-saving medications such as epi-pens or inhalers.* All medications need to be picked up by a parent on the first school day after the trip returns.
PLEASE NOTE:

- All medications must come in the original container. No baggies, pill boxes, or unlabeled medications will be accepted. Please send only the amount needed for the trip.
- Physician signature is required for prescription medications only.
- If your student already has a current *emergency* medication and current emergency care plan on file at school, (ie. Epi-pen, inhaler, glucagon), it will automatically be sent on the retreat/trip, along with the authorization form that is on file. You do not have to bring additional forms or medications, unless there has been a change in the physician's orders.

1. Name of drug: _____
   Dose/Method/Times: _____
   Reasons for medication (diagnosis, anticipated effect): _____
   Undesired reactions: _____
   Physician Signature (if needed) _____

2. Name of drug: _____
   Dose/Method/Times: _____
   Reasons for medication (diagnosis, anticipated effect): _____
   Undesired reactions: _____
   Physician Signature (if needed) _____

Physician Name: _____ Phone: _____
Office Stamp: