STUDENT NAME: _____DATE OF BIRTH: _____GRADE/TEACHER: _____

OCS OVERNIGHT FIELD TRIP/RETREAT MEDICATION ADMINISTRATION AUTHORIZATION

In agreement with the mandates of the state of Michigan, it is the policy of Oakland Christian School to have appropriate written authorization for the administration of medication to students while in attendance at an overnight school field trip/retreat. Both parent and physician signatures are required if the medication is a prescribed medication being administered by OCS staff.

If you are a parent/guardian attending/chaperoning this trip, you may administer your student/child's medications. However, you must complete Part 1 of this form and sign and check the box at the bottom of this page to confirm that you will supervise your child's- and ONLY your child's- medication administration.

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

PART 1- *Over the Counter Medication*: **ALL** parents must complete Part 1 of this form for authorization and administration of over-the-counter (OTC) medications, such as (but not limited to): Tylenol (tablets), Advil (tablets), cough drops, Tums, Benadryl, Claritin, saline eye drops, triple antibiotic ointment, hydrocortisone cream, etc., to be administered to your child while he/she is at an overnight school sponsored trip. *We will have most of these medications on hand, and request that parents refrain from sending additional OTC medications; please only send REQUIRED medications for students. * All information will be handled in a confidential manner. PLEASE refrain from sending any/all unnecessary OTCs, vitamins, supplements, etc. if possible.

Student's Name: _____ Date of Birth: _____ Grade: _____

Student's Weight:_____ Student Height: _____ (for medication dosing)

List Medication Allergies or medical conditions: _____

Comments/Concerns:_____

I hereby authorize designated OCS staff to give over-the-counter medication to the above-named student on an as needed basis.

Parent/Guardian (s) Name: _____ Phone #: _____

Parent Signature: _____ Date: _____

PART 2- *Prescription Medication*: ALL students requiring **prescription medications**, including- but not limited to- antibiotics, EpiPens, inhalers, AND any other prescribed, daily medication, MUST complete Part 2, with an **additional signature from your doctor**. If you have already completed and filed an OCS Medication Administration Authorization Plan and/or an Asthma Action Plan for your student with the OCS school nurse this school year for a prescribed medication, then you do not need a new form; please request that form to be utilized for your student's trip by contacting nurse@oaklandchristian.com. If you do *not* have this plan in place at school, then ALL other prescribed medications require completion of the second page of this document ("Prescriber's Authorization for Medication") and MUST have signatures from BOTH the parent and the physician.

PLEASE NOTE: All medications must be dropped off to school personnel by a parent at registration. Please allow time for this at- or days prior- to check-in. NO medications are allowed in the student's possession at any time, other than life-saving medications such as EpiPens or inhalers. All medications will be evaluated and counted at check-in and will need to be picked up by a parent on the first school day after the trip returns. All medications must come in the original, labeled containers- ***NO** baggies, pill boxes, nor unlabeled medications will be accepted at check in.* Also, if a physician's signature is not obtained properly, your student will not be allowed to receive any/all prescribed medication on his/her trip and will run the risk of not being able to attend the field trip. PLEASE refrain from sending any/all unnecessary vitamins, supplements, etc. if possible.

PARENT/GUARDIAN AUTHORIZATION: I, _____, PARENT OF _____, hereby authorize school personnel to administer medication to the above-named student according to the physician's directions as given below.

☐ I am a parent/legal guardian chaperoning the trip AND I will carry and administer my above-named child's medication.

Parent Signature: _____ Date: _____

STUDENT NAME: _____ DATE OF BIRTH: _____GRADE/TEACHER: _____

PRESCRIBER'S AUTHORIZATION FOR PRESCRIBED MEDICATIONS:

MEDICATION NAME: _____

Reason for medication (diagnosis, condition): _____

Dose: _____Route: _____ Time/frequency of administration: _____

If PRN, frequency: _____If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify:_____

Comments (include any request for personnel observation and report):_____

MEDICATION NAME: _____

Reason for medication (diagnosis, condition): _____

Dose: _____Route: _____ Time/frequency of administration: _____

If PRN, frequency: _____If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify:_____

Comments (include any request for personnel observation and report):_____

Physician's Signature: _____

Physician's Printed Name:_____ Physician's Phone Number: _____

Address: _____

****

PARENT (or physician)- PLEASE use chart below to specify directions needed for OTC or Prescription medications:

MEDICATION NAME/ Reason:	**Dosage/ Amount of pills to be given:**	Circle TIMES to be given: B- Breakfast L- Lunch D- Dinner HS- Bedtime PRN- As needed
		B L D HS PRN
		B L D HS PRN
		B L D HS PRN
		B L D HS PRN