

OVERNIGHT Medication Administration (5th-8th Grades)

Spring Valley Academy 2026-2027 School Year

Name of Student: _____ Date of Birth: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Choose ONE of the options to indicate the medication requirements for your student while participating in overnight school-sponsored trips. Please note that it is your responsibility to update this form should any changes occur during the school year.

Option 1:

My student DOES NOT require any medication (including vitamins, supplements, herbal remedies, over-the-counter and/or prescription medications) OR a parent will be available during trips to manage his/her medication(s).

Parent Initial: _____ (Form is complete, please turn form in to the nurse)

Option 2:

I am requesting that the designated staff member or healthcare professional be in charge of carrying and administering my student's medication(s) during trips.

Parent Initial: _____ (Form is INCOMPLETE until back side is completed and signed by parent for vitamins, supplements, herbal remedies, and over-the-counter medications. If the medication is prescription, we must have a medication authorization form for each medication. Without a medication authorization, prescription medications will not be made available for your student).

Questions? Please contact Kristen Pulido, SVA School Nurse at (937) 433-0790 or krpulido@springvalleyacademy.org

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

FOR VITAMINS, SUPPLEMENTS, HERBAL REMEDIES AND OVER-THE-COUNTER MEDICATIONS:

I am requesting that my student be administered their vitamins, supplements, herbal remedies, over-the-counter, and prescription medications by the designated staff member. As the parent, I will provide the medication(s) in the original container(s). If the medication(s) is/are prescribed by a provider, all will come in the pharmacy container(s) with the correct pharmacy label(s). I will notify the school of any changes to the medication(s) and will have the provider update the medication authorization as necessary to reflect the new medication, dose, route to be given, time to be given, etc.

Parent/Guardian Signature: _____ Date: _____

List all vitamins, supplements, herbal remedies, over-the-counter and prescription medications. If not listed below (with a medication authorization for prescription medications), it will not be permitted to be available during trips:

Medication Name: _____ Dose: _____ Times: _____

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Medication Name: _____ Dose: _____ Times: _____

Medication Name: _____ Dose: _____ Times: _____

Medication Name: _____ Dose: _____ Times: _____

Medication Name: _____ Dose: _____ Times: _____

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