

**OVERNIGHT Medication Administration (9<sup>th</sup>-12<sup>th</sup> 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) during trips OR a parent will be available during the 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 my student be able to self-carry and self-administer his/her own medication for trips.  
**\*Self-carry is not an option for any stimulant medications for the treatment of ADHD.**

**Parent Initial:** \_\_\_\_\_ (Form is INCOMPLETE until back side is completed and signed by parent and student 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).

**Option 3:**

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 and student 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).

Student's Name: \_\_\_\_\_ Student's Date of Birth: \_\_\_\_\_

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

I am requesting that my student be able to self-carry and self-administer his/her medication(s) for trips. My student has been instructed on each medication, it's purpose, it's recommended dosage, and my student feels comfortable in self-administering. My student is solely responsible for his/her medication(s) and will never share or let other students use his/her medication(s). My student will report any adverse side effects to a staff member promptly, as well as let the staff member in charge know if the medication(s) were taken in error or if the dosage(s) were incorrect. 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. I understand that the staff can revoke the right for the student to self-administer medication(s) at any time if the staff member feels the student is being unsafe or is violating any of the procedural safeguards in place.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student 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 be confiscated and not permitted to be available during trips:**

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Times: \_\_\_\_\_

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Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Times: \_\_\_\_\_