Medication Authorization for SOOD

Please read the following, sign, and return this form with medications by Wednesday,10/01, *ONLY if your child will need medications while at SOOD*. (Due to processing time, last minute medications cannot be accepted.)

- Any medication that is administered during SOOD, either over the counter or prescribed, requires parent/guardian authorization. This applies to any medication given by mouth, injection, or applied topically.
- The following over-the-counter medications will be provided, as needed: Acetaminophen (Tylenol), Ibuprofen (Advil), Diphenhydramine (Benadryl), Calamine gel, calcium carbonate (Tums), eye wash, and sting relief. (Per your prior permission in Annual Forms on the parent portal.)
- **Students should carry their own emergency medications** (Epi-pens, inhalers, insulin, etc.) Please list any emergency medication(s) below and note that your child will self-carry.
- **Any other medications that your child may need must be provided to the school in the original container with proper labeling, as required by OK State Department of Health guidelines.**
- Please send only the amount needed for the length of the trip or event. (Ex. send 1 pill in the bottle. You keep the remaining pills in a baggie at home.)
- Prescription medications will only be administered as prescribed by the physician, noted on the prescription label. (For as needed medications, please note the reason for administration. Ex: for migraine.)
- Over the counter medications will be given per your instruction, provided this corresponds with label instructions.
- Only FDA approved medications will be accepted.
- Medications will be given by a Holland Hall School employee/chaperone authorized to administer medication for this event only.

Child's Name _____ DOB:_____ GRADE_____

My child requires the following medications to be administered while on SOOD.

Medication _____ Dosage to be given: _____ caps/pills/tabs
Time(s): _____ Reason (Diagnosis): _____

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Time(s): _____ Reason (Diagnosis): _____

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Medication _____ Dosage to be given: _____ caps/pills/tabs
Time(s): _____ Reason (Diagnosis): _____

Parent/Guardian signature: _____ Date: _____