BOB JONES ACADEMY

Authorization For Medication On A School Trip

On the day of departure, give this form and medication directly to the staff member administering medication.
Please send only the amount needed for the trip.

Student's Name _____ Date of Birth _____

Date(s) of the trip _____ Destination _____

Name of Medication	Dosage	Time to be Given	Possible Side Effects

- I understand that all medications will be provided **in the original container, clearly marked with my child's name**
- I give permission to share this information with other individuals who will have direct responsibility for my child.
- The first dose will be given at home so that I can monitor adverse reactions.
- I give my permission for the designated BJA staff member to administer this medication according to the instructions provided. I understand that BJA staff will not administer doses that exceed prescription dosage or frequency.
- I agree not to hold Bob Jones Academy responsible for any adverse reactions or outcomes.

Parent/Legal Guardian Printed Name:_____ Phone Number: _____

Signature of Parent/Legal Guardian:_____ Date:_____

FOR TEACHER'S USE—DO NOT WRITE BELOW THIS LINE.

Name of Medication	Dosage	Date and Time Given	Initials

_____

Signature of BJA staff member giving medications Initials