

## Youth Program Parent/Guardian Authorization, Waiver, and Consent for Over-the-Counter Medication Form

### PROGRAM INFORMATION

Program Name: \_\_\_\_\_ (hereafter "Program")

Date(s): \_\_\_\_\_

Time(s): \_\_\_\_\_

Location: \_\_\_\_\_

### PARTICIPANT INFORMATION

Participant Name: \_\_\_\_\_ (hereafter "Participant")

Parent/Legal Guardian Name: \_\_\_\_\_

Select Over-the-Counter (OTC) medication may be provided if the Program has written permission from the Participant's parent or guardian. **Note: Unless we have parental authorization, we will not make OTC medications available to participants unless necessary as part of general first-aid treatment.**

I hereby authorize that the following medications may be given to Participant consistent with medication directions, if the need arises. The Program may provide only those checked.

Ointments for minor wound care, first aid (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)

Tylenol/Acetaminophen

Ibuprofen

Throat lozenges and or spray for sore throat

Micatin or anti-fungus treatment for athlete's foot

Kaopectate or Imodium for diarrhea

Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea

Roloids or Tums for acid reflux, heartburn, or indigestion

Benadryl for swelling, hives, allergic reaction

Actifed or Sudafed for nasal congestion or allergy relief

Visine or other eye drops for minor eye irritation

Medicated lip ointment for dry, chapped lips, lip blisters or canker sores

Swimmer's ear drops

Hydrocortisone ointment for mild skin irritations, poison ivy, and insect bites

Medicated powder for skin irritation

Robitussin or other cough syrup

Calamine lotion for bug bites and poison ivy

Sunscreen

Bug repellent

Other (list any other approved over-the-counter drugs)

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.

I understand that such medication will not be given under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above-outlined treatment will be followed-up by a consultation with the Participant's parent/guardian. The parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless the Youth Program, Youth Program Personnel, Auburn University; its Board of Trustees, individually and collectively; Administrators; Faculty; Staff; and all other officers, directors, employees, and agents against any claims that may arise relating to my child being administered the above-indicated over-the-counter medications.

I/We have legal authority to consent to medical treatment for the Participant named above, including the administration of medication at the above-referenced program.

Parent/Guardian Name  
Parent/Guardian Signature

Date: