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")

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 or generic equivalents 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
- ☐ Rolaids 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)

_____

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 at Montgomery; 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:** _____

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 19