

Permit to Administer/Dispense Over the Counter (OTC) Medication

Student Name: _____ **Date of Birth** _____

Parent/Guardian Name: _____

Home Phone: _____ **Work Phone:** _____

Please list any allergies: _____

Please list any long term medication (s) taken and the reason for taking the listed medication (s): _____

OTC (Over The Counter) Medications):

Please read and sign the following for the administration of medication to your child, or initial the Administer no Medication statement.

Do NOT Administer Medication: _____ (parent/guardian initial's).

I, _____, by below signature, hereby hold the specified Athletic Coach, and the school harmless in the administration of pre-packaged non-prescription (OTC) medications to the above listed student. I understand that the Athletic coach will provide the medication in a single dose only. No medications will be given for long-term use (longer than 5 consecutive days.) Anahuac I.S.D. and the licensed Athletic coach accepts NO responsibility for OTC medications that are defective, either by their design or dosage recommendations or that are misused by the athlete. The misuse of medications will result in the athlete's loss of medication privileges.

Parent/Guardian Signature: _____

Date: _____

I hereby grant by initials permission for the specified Athletic Coach to administer the following OTC medications

Only initial those that you desired administered.

*Listed are the brand names and their active ingredients-please not, actual medications may be of a generic name.

- | | |
|---|-------------------------------------|
| _____ Tylenol (acetaminophen) | _____ Advil (ibuprofen) |
| _____ Aleve (naproxen sodium) | _____ Sudafed (pseudoephedrine HCL) |
| _____ Midol (acetaminophen & pamabrom) | _____ Tums (calcium carbonate) |
| _____ Benadryl (diphenhydramine HCL) | _____ Cough Drops (menthol) |
| _____ Throat Spray/Lozenge (phenol) | _____ Fosfree (electrolytes) |
| _____ Pepto-Bismol (bismuth subsalicylate) | |
| _____ Anti-Itch/Fungal Cream/Spray (hydrocortisone) | _____ Immodium (anti-diaarhea) |

List any other medications that you may wish to be provided:

1. _____ **Dosage:** _____
2. _____ **Dosage:** _____
3. _____ **Dosage:** _____

This authorization shall remain effective until the end of the _____ school year.