Oklahoma State University Youth Program/Camp
Parent/Guardian Authorization, Waiver and Consent for Over-the-Counter Medication Form

PROGRAM/CAMP INFORMATION

Program/Camp Name: __________________________

Date(s): ___________________ Time(s): ________________ Location: ____________________________

PARTICIPANT INFORMATION

Participant Name: ____________________________

Parent/Legal Guardian Name (if applicable): ____________________________

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant’s parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay.

Note: Unless we have parental authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to Participant if the need arises. You may dispense only those checked.

___ Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
___ Tylenol/Acetaminophen as directed.
___ Ibuprofen as directed.
___ Throat lozenges and or spray as directed for sore throat.
___ Micatin or anti-fungus treatment as directed for athlete’s foot.
___ Kapectate or Imodium for diarrhea as directed.
___ Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.
___ Rolaidos or Tums for acid reflux, heartburn or indigestion as directed.
___ Benadryl for swelling, hives, allergic reaction, as directed.
___ Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
___ Visine or other eye drops for minor eye irritation.
___ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
___ Swimmer’s ear drops as directed.
___ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.
___ Medicated powder for skin irritation as directed.
___ Robitussin or other cough syrup as directed.
___ 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 administration will not be done 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 student’s parents. 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 Program Staff, Oklahoma State University, its Board of Regents, Administration, Faculty, Staff, Student Leaders, 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 student named above, including the administration of medication at the above referenced program.

Parent/Guardian Signature ____________________________ Date ____________________________