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

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Home Phone: _____ Work/Cell Phone: _____

Please list any allergies: _____

OTC (Over The Counter) Medications:

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

Administer NO Medication: _____

I, _____, by below signature, hereby hold the Certified Athletic Trainers, Benjamin Franklin High School, and Ochsner Health System harmless in the administration of pre-packages, non-prescription (OTC) medications to the above listed student. I understand that the Certified Athletic Trainers will provide the medication in single dose only. Ochsner Health System, Benjamin Franklin High School, and the Certified Athletic Trainers accept 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 certified athletic trainers to administer the following OTC medications:

Only initial those that you desire administered

* Listed are brand names and their active ingredients- please note, actual medications may be of a generic name.

____ Advil (Ibuprofen)

____ Pepto-Bismol (Bismuth subsalicylate)

_____ Tylenol (Acetaminophen)

_____ Electrolyte Tablets