TEXAS A&M AGRILIFE EXTENSION

OTC

Parent Guardian Authorization, Waiver, & Consent for Over-the-Counter Medication

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the youth's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during her/his stay. Note: Unless we have parental authorization, we cannot administer ANY medications.

Participant name _____ Date of birth _____ Age _____

County _____ District _____ Name of Event Attending _____

- ☐ Ointments for minor wound care, first aid (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn) as directed.
- ☐ Tylenol/Acetaminophen as directed
- ☐ Ibuprofen as directed
- ☐ Kaopectate or Imodium for diarrhea as directed
- ☐ Rolaids or Tums for acid reflux, heartburn, or indigestion as directed
- ☐ Benadryl for swelling, hives, allergic reaction, as directed
- ☐ Medicated powder for skin irritation as directed
- ☐ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites
- ☐ Robitussin or other cough syrup as directed
- ☐ Sunscreen
- ☐ Milk of Magnesia, Pepto Bismol, or Mylanta for upset stomach or nausea as directed.
- ☐ Calamine lotion for bug bites and poison ivy
- ☐ Micatin or anti-fungus treatment as directed for athlete's foot
- ☐ Visine or other eye drops for minor eye irritation
- ☐ Actifed or Sudafed as directed for nasal congestion or allergy relief as directed
- ☐ Throat lozenges and/or spray as directed for sore throat
- ☐ Swimmer's ear drops as directed
- ☐ Medicated lip ointment for dry, chapped lips, lip blisters, or canker sores as directed
- ☐ Bug repellent

Other (list any other approved OTC drugs): _____

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

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 authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless for any all purposes program staff, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M AgriLife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees (RELEASEES) against any claims that may arise relating to my child being administered the above indicated over-the-counter medications ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES***.

I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the program hosted by/at Texas A&M AgriLife Extension.

Participant Name _____ Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Adapted from Auburn University's Summer Experience Required Form Packet, http://www.auburn.edu/student_info/auband/event/summer_camps/documents/2014_medical_form.pdf

TEXAS A&M AGRILIFE EXTENSION

SAP

Parent Guardian Authorization, Waiver, & Consent for Self-Administration of Prescription Medication -- Participants 15 years of age or older

This portion of the form must be completed fully in order for participants to self-administer required medication. This form must be completed for each camp/program attended by the youth, for all medications, and each time there is a change in dosage or time of administration of a medication.

Participant Name _____ Date of birth _____ Age _____

County _____ District _____

Name of Event Attending _____ Event Date(s) _____

☐ No, my child does not need to take any prescription medication while at the program

☐ Yes, my child will need to take prescription medication while at the program

All prescription medications, including medications for conditions such as food, drug or insect allergies, diabetes; asthma; or epilepsy may be brought to the program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at program by a parent/legal guardian. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the youth will be attending the program.

Medication Name: _____ Dose: _____

Specific Directions (i.e. on empty stomach, with water, etc.): _____

_____

Time/Frequency of administration: _____

Relevant side effects:

_____

Special Storage Requirements (if any): _____

Is the participant capable of self-managed care? Yes ☐ No ☐

Prescribing Physician: _____

Telephone: _____

I authorize and recommend self-medication by my child for the above medication. I also affirm that s/he has been instructed in the proper self-administration of the prescribed medication(s) by her/his attending physician. I agree to indemnify and hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M AgriLife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees against any claims that may arise relating to my child's self-administration of prescribed medication(s) *including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES*.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Adapted from Auburn University's Summer Experience Required Form Packet, http://www.auburn.edu/student_info/auband/event/summer_camps/documents/2014_medical_form.pdf

TEXAS A&M AGRILIFE EXTENSION

Authorization to Dispense Medication

ADM

Participant: _____ Food Allergy (if applicable):_____ Medication (*Listed Below)*

All medication to be administered must comply with the following guidelines:

1. All medication, including over-the-counter, must be in the **original container**. All prescription medication must be in the participant's name. Sharing of prescription medication is not allowed. Inhalers must be accompanied by the prescription label.
2. All medication must be accompanied by this dated medication authorization form signed by the parent / legal guardian.
3. Please include instructions for over the counter medications.
4. **All medication, including over-the-counter, will be given ONLY as directed on the label**.
5. If there has been a change in the dosage, please send a note from the participant's doctor reflecting the change.

List all medications your child will be taking. **Prescriptions will be given as directed on the label.**

Medication	Dosage	Time to be given	Special instructions	Staff use only, please do not write here.						

By signing below, I certify that the information is true and complete. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Name (Parent/Guardian: _____ Signature:_____ Date _____