



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: _____

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.

Administer No Medication: _____

I, _____, by below signature, hereby hold the certified athletic trainer, Peak Performance Physical Therapy, and Episcopal harmless in the administration of pre-packaged, non-prescription (OTC) medications to the above listed student. I understand that the certified athletic trainer will provide the medication in single dose only. No medications will be given for long term use (longer than 5 consecutive days). Peak Performance Physical Therapy, Episcopal and the certified athletic trainer 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 trainer 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)

_____ Aleve (naproxen sodium)

_____ Pepto-Bismol (bismuth subsalicylate)

_____ Heat Guard (electrolytes)

_____ Benadryl (diphenhydramine HCL) – for allergic reactions

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

This authorization shall remain effective until the end of the 2005/ 2006 school year.