



**PARENT/LEGAL GUARDIAN AUTHORIZATION, WAIVER, AND CONSENT
FOR OVER-THE-COUNTER MEDICATION (optional)**

Minor Participant Full Legal Name: _____
(hereafter "Participant")

Participant Date of Birth (MM/DD/YY): _____

Program Name (hereafter "Program"): _____

Program Date(s): _____

Over-the-Counter Medication

- Select Over-the-Counter (OTC) medication may be provided if the Program has written permission from the Participant's parent or legal guardian.
- Programs are not required to stock any OTC medications and may not have the checked medications.
- Note: Unless parental authorization is obtained, OTC medications will not be made available to participants unless necessary as part of general first-aid treatment by a trained medical professional.
- Parents/legal guardians may list OTC medications on the Youth Programs Medical Information and Authorization Form and provide them to their minor participant for self-administration.

I hereby authorize that the following medications may be given to Participant consistent with medication directions, if the need arises. The Program may provide only those checked.

- ☐ Ointments for minor wound care or first aid (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
- ☐ Tylenol/Acetaminophen
- ☐ Ibuprofen
- ☐ Throat lozenges and or spray for sore throat
- ☐ Micatin or antifungal treatment for athlete's foot
- ☐ Kaopectate or Imodium for diarrhea
- ☐ Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea
- ☐ Rolaids or Tums for acid reflux, heartburn, or indigestion
- ☐ Benadryl for swelling, hives, allergic reaction



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- ☐ Actifed or Sudafed for nasal congestion or allergy relief
- ☐ Visine or other eye drops for minor eye irritation
- ☐ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores
- ☐ Swimmer's ear drops
- ☐ Hydrocortisone ointment for mild skin irritations, poison ivy, and insect bites
- ☐ Medicated powder for skin irritation
- ☐ Robitussin or other cough syrup
- ☐ Calamine lotion for bug bites and poison ivy
- ☐ Sunscreen
- ☐ Bug repellent
- ☐ Other (list any other approved over-the-counter medications): _____

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- 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 medication will not be given under the supervision of medical personnel.
 - 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 participant's parent/legal guardian. The parent/legal 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 minor participant as indicated above. I acknowledge that the administration of medication pursuant to this authorization involves potential risk of personal injury, including the possibility of broken limbs, paralysis or even fatal injury. Nonetheless, being fully aware of the dangers, I desire the administration of medication pursuant to this authorization and voluntarily assume all risk of loss, damage or injury. I understand and agree that Virginia Commonwealth University, its agents, employees, officers, directors and assigns are not responsible for any and all claims, damages, losses, injuries, and expenses arising out of or resulting from the administration of medication pursuant to this authorization.
 - I have legal authority to consent to medical treatment for the Participant named above, including the administration of medication at the above-referenced program.

Parent/Legal Guardian's Name (Please Print)

Parent/Legal Guardian's Signature

Date



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