

I give sponsors/chaperones permission to give my child the following Over-the-Counter medications (please circle "yes" or "no")

- | | | |
|-----------------------------|-----|----|
| • Tylenol | Yes | No |
| • Ibuprofen (Advil, etc.) | Yes | No |
| • Aspirin | Yes | No |
| • Motrin | Yes | No |
| • Midol | Yes | No |
| • Diarrhea Medication | Yes | No |
| ○ Imodium | Yes | No |
| • Upset Stomach Medication | Yes | No |
| ○ Peptol Bismol | Yes | No |
| • Tums | | |
| • Dramamine/Motion Sickness | Yes | No |

Please list any medication your child cannot take:

I understand that I will provide all prescription medication. I will also provide non-prescription medication that must be taken on a daily basis. Medications, in the original bottle/container, must be placed in a zip lock type bag. Please include an index card with the student's name, medication and clear instructions in the bag.

Authorization by Parent or Guardian to Provide Medical Care for a Minor Child

Name of Child: _____
(Last) (First) (Middle)

Full Name of Father: _____

Full Name of Mother: _____

In the event of sickness or accident, the sponsors and/or chaperones are granted the permission to seek any and all medical attention for the above named child. Also, I grant permission to any medical facility and/or physician that are licensed to provide this care, and approved by the sponsor and/or chaperone, to give any and/or all needed medical care and treatment to my child. This permission is granted in the absence of me/us as the parent or guardian of the minor child.

Signature of Parent/Guardian

Father: _____ E-Mail: _____

Address: _____ Phone #: _____

Signature of Parent/Guardian

Mother: _____ E-Mail: _____

Address: _____ Phone #: _____