FORM B2

AUTHORIZATION FOR DISPENSATION OF OVER-THE-COUNTER MEDICATION

Program Information

Program Name: _____
Date(s): _____
Location(s): _____

[Note: The program information should be filled in by the Program Director]

Participant Information

Participant Name: _____
Address: _____
City, State, Zip Code: _____
Date of Birth: _____
Gender: _____

Over-the-counter medication ("OTC medication") may at times need to be dispensed to a participant in the above-described program if approved by the participant's parent or legal guardian. Please complete this form to save time if you choose to authorize Program staff to offer OTC mediation to the participant described above ("Participant") during the Program. **NOTE: The University of Tennessee will not dispense any OTC medication without the written authorization of a participant's parent or legal guardian.**

I authorize Program staff to offer the following medications to Participant if the need arises, in the sole judgment of the staff of the Program, as directed on the manufacturer's container (check the blanks below for each OTC medication(s) you authorize):

☐ Ointments for minor wound care, first aid as directed (e.g., antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
☐ Tylenol/Acetaminophen
☐ Ibuprofen
☐ Throat lozenges and/or spray for a sore throat
☐ Micatin or other anti-fungus 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, or allergic reaction
☐ 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, or insect bites
☐ Medicated powder for skin irritation
☐ Robitussin or other cough syrup
☐ Calamine lotion for bug bites and poison ivy
☐ Sunscreen
☐ Insect repellant
☐ Other (list any other approved OTC medications): _____

Program staff reserves the right to use generic equivalents when available for the name brand OTC medications identified above.

If Participant is allergic to any type of OTC medication, please identify the OTC medication(s):

_____

Program staff will contact Participant's emergency contact if Participant has any condition associated with fever.

I hereby authorize the dispensation of OTC medications to Participant as indicated above. I understand that such dispensation will not be done under the supervision of medical personnel. I understand that the OTC medications indicated above are not necessarily kept on hand and may not be available to be dispensed immediately.

Signature of Participant's Parent or Legal Guardian: _____

Printed Name of Participant's Parent or Legal Guardian: _____

Date: _____