



BROKEN ARROW ATHLETIC TRAINING

CONSENT FOR ADMINISTRATION OF "OVER-THE-COUNTER" MEDICATIONS

Student Athlete's Name: _____

Medication Allergies: _____

List Any Medications Your Child Receives Regularly: (Including any medicine used for asthma)

I give my permission for my child _____ to receive any medication I have indicated below as deemed necessary by the certified athletic trainer and/or team physician. I understand that generic equivalent medications may be used in place of more expensive brand-name items.

Please check medication(s) you wish to be made available to your child under medical staff discretion:

For headache/fever/muscle aches:

- Acetaminophen** (Tylenol), 1 or 2 – 500 mg tabs every 4-6 hours for headache or fever
- Ibuprofen** (Advil/Motrin) 1 or 2 – 500 mg tabs every 4-6 hours, not to exceed 6 tabs in 24 hours-for headaches, mild to moderate skeletal discomfort.

For mild cold symptoms:

- Cough Drop**, 1 or 2 for mild throat discomfort, mild cough.
- Cough Suppressant**, 2 tsp every 4-6 hours for cough

For mild stomach discomfort:

- Antacid**, 2 tabs (Tums or generic equivalent) for mild to moderate hyperacidity.

I DO NOT WANT ANY MEDICATIONS TO BE GIVEN TO MY CHILD AT SCHOOL/ATHLETIC ACTIVITIES.

I understand the above mentioned medications I have checked will be administered by the team physician or certified athletic trainer in accordance with established protocols endorsed by the team physician.

Signature of Parent/Guardian

Date

