Over the Counter & Prescription Medication Summary

4-H'ers Name _____ **County** _____

Parent/guardian should list any over-the-counter medication that may be given to the 4-H'er in case of illness. In addition, list any/all medication routinely taken by the 4-H'er including prescription and over the counter medications.

Check Yes or No to indicate if you allow your child to receive the following medications while participating in 4-H programming.

1. Administration of Acetaminophen (Tylenol ®) or Ibuprofen (Motrin ® or Advil ®) at an age appropriate or weight appropriate dose for discomfort, pain, or fever
   ■Yes ■ No *** Parent/Guardian will be contacted if student's fever is 100° F or higher.
2. Antacid liquid or Antacid tablets for indigestion/minor stomach discomforts and at an age appropriate dose
   ■Yes ■No
3. Diphenhydramine (Benadryl®) for symptoms of allergic reactions, insect stings, or rashes at an appropriate dose
   ■Yes ■No
4. Sore throat relief spray for sore throat
   ■Yes ■No
5. Cough Drops for coughing
   ■Yes ■No
6. Itch and rash relief cream/ointment for minor skin irritations
   ■Yes ■No
7. Lubricating eye drops for eye irritations
   ■Yes ■No
8. Oral pain relief gel for tooth/mouth discomfort
   ■Yes ■No
9. Triple antibiotic ointment for minor skin abrasions/wounds
   ■Yes ■No

Please list any prescription, over-the-counter, or homeopathic medications your child is currently taking. This information is necessary if your child is to be treated by a medical professional. Examples: Claritin, vitamins, etc. If the following medication should be administered during this event, complete the Georgia 4-H Medicine Form. Any medications brought to a program must be in its original container, unexpired, and clearly labeled with the 4-H'ers name. Youth may not share any medication with others.

All medications should be turned in to program/activity leaders at the program start and should accompany a Georgia 4-H Medicine Form. Any exceptions to this (such as an inhaler for asthma or an epi-pen for allergic reactions) must be verified with a 4-H staff member prior to the event.

Medication	Condition being treated for

I am the parent/guardian of _____ and give permission for the medications listed to be administered as directed. By signing below, I am agreeing the information is currently correct. I agree to notify 4-H immediately in writing should any of this information change. I also understand that I will be notified if my child distributes or shares any prescription, over-the-counter, or homeopathic medication, or if my child is found to be in possession of any medications not listed on this form.

_____ _____

Parent/Guardian Signature **Date**

PLEASE COMPLETE BOTH SIDES