

**OVER THE COUNTER MEDICATION PERMISSION  
Girl Scouts of San Jacinto Council**

I \_\_\_\_\_ (parent / guardian) give permission for the Girl Scouts of San Jacinto Council to administer the following over-the-counter medications or their generic equivalent to my daughter, \_\_\_\_\_ (name), if the nurse or advanced first aider deems it necessary. Dosages will be administered according to directions on the package unless a physician directs otherwise. This agreement is valid for one year, unless otherwise specified.

*(Please mark through any medications that you do **not** want your daughter to have.)*

Pain and Fever	Digestive / Allergy	Other Medications
Tylenol (Acetaminophen)	ImodiumAD (loperamide/simethicone)	First Aid Ointment
Advil (Ibuprofen)	Kaopectate	Tums
Aspirin	Pepto-Bismol (bismuth subsalicylate)	Antibiotic Cream
Aleve (Naproxen Sodium)		Cold Capsule
Midol/Pamprin	Calamine Lotion	Cough Drops / Syrup
Other _____	Benadryl	Throat Lozenges
Other _____	Decongestant (pseudoephedrine)	Aloe Vera Burn Relief
Other _____	Other _____	Other _____

My daughter is allergic to the following medications:

\_\_\_\_\_

\_\_\_\_\_

My daughter is allergic to the following Foods, Plants, and Pests (Insects):

\_\_\_\_\_

\_\_\_\_\_

My daughter takes the medications listed below on a regular basis (Please include both prescription and non-prescription medicines).

<u>Medicine</u>	<u>Usual Dosage</u>
_____	_____
_____	_____
_____	_____
_____	_____

**NO MEDICATION WILL BE DISPENSED WITHOUT PARENT/GUARDIAN SIGNATURE.**

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Phone Number(s): (hm.) \_\_\_\_\_ (cell/pg) \_\_\_\_\_ (wk) \_\_\_\_\_

Signature of Witness (not camp staff) \_\_\_\_\_ Date \_\_\_\_\_