

Over the Counter Medication

Participant _____

The following over the counter medication is available for dispensing. Dosages will be administered according to the directions on the bottle unless a physician directs otherwise.

Headache or pain- Tylenol

Upset stomach- Pepcid AC

Diarrhea- Imodium AD

Menstrual Cramps- Ibuprofen

Poison Ivy or insect bites- Cortaid

Minor Cuts or scrapes- Neosporin Plus

Please check below the statement that best describes your permission.

_____ I give permission for Leigh Ann's Horses for Attachment to administer the over the counter medication as deemed necessary.

_____ I wish to provide a substituted over the counter medication to be used with my child when Leigh Ann's Horses for Attachment deems necessary. Such medication must be in original bottle with dosage instructions provided. You must cross out the above medication you are replacing and provide the name of the preferred medication. Then you are giving us permission to administer as needed.

_____ I would like to be contacted prior to any over the counter medication being administered.

_____ I don't want any over the counter medications administered to my child.

Signature _____ Date _____