

GIRL SCOUTS OF THE PERMIAN BASIN



AUTHORIZATION FOR DISPENSING OVER THE COUNTER MEDICATION

You have my permission to administer the following medication as you feel it is necessary to

_____.

(name of child)

Tylenol mg. _____

Pepto Bismol

Kaopectate

Antacid

Alka Seltzer

Motrin

Benedryl

Other _____

Signature: _____

Parent or Guardian

*All medications, including aspirin products and anti-histamines must be given to the adult sponsors along with this authorization.



AUTHORIZATION FOR DISPENSING PRESCRIPTION MEDICATION

First Aider or equally qualified medical person has permission to administer the following medication to

(name of child)

MEDICINE MUST BE IN ITS ORIGINAL CONTAINER WITH THE CHILD'S NAME CLEARLY PRINTED.

Prescription Drug

Prescribing physician: _____

Prescription number: _____

Name of medication: _____

Dosage:(mg.) _____

When to give: _____

Continue this medication until _____

(date)

Signature: _____

Parent or guardian

Date

Address _____ Phone (day) _____

(evening) _____