Appendix B:

Cleveland State University Youth Program/Camp Parent/Guardian Authorization, Waiver and Consent for Over-the-Counter Medication Form

PROGRAM/CAMP INFORMATION

Program/Camp Name: _____(hereafter "Program")

Date(s): _____Time(s): _____Location: _____

PARTICIPANT INFORMATION

Participant Name: _____(hereafter "Participant")

Parent(s)/Legal Guardian(s) Name (if applicable): _____

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay.

Note: Unless we have parental authorization, we CANNOT administer ANY medications.

I/We hereby authorize that the following medications may be given to Participant if the need arises. You may dispense only those checked.

____ Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)

____ Tylenol/Acetaminophen as directed.
____ Ibuprofen as directed.
____ Throat lozenges and or spray as directed for sore throat.
____ Micatin or anti-fungus treatment as directed for athlete's foot.
____ Kaopectate or Imodium for diarrhea as directed.
____ Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.
____ Rolaids or Tums for acid reflux, heartburn or indigestion as directed.
____ Benadryl for swelling, hives, allergic reaction, as directed.
____ Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
____ Visine or other eye drops for minor eye irritation.
____ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
____ Swimmer's ear drops as directed.
____ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.

____ Medicated powder for skin irritation as directed.
____ Robitussin or other cough syrup as directed.
____ Calamine lotion for bug bites and poison ivy.
____ Sunscreen
____ Bug repellent
Other (list any other approved over-the-counter drugs)
_____

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.

I/We understand that such administration will not be done under the supervision of medical personnel. I/We also agree that any first aid treatment may be given as needed.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the student's parents/guardians. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I/We understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I/We authorize the administration of over-the-counter medications to my/our child as indicated above. I/We shall indemnify and hold harmless the Program Staff, the State of Ohio, Cleveland State University, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my/our child being administered the above indicated over- the-counter medications. I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at the above referenced program.

Participant Name _____
Participant's Signature _____ Date _____

Parent/Guardian Name _____
Parent/Guardian Signature _____ Date _____

Parent/Guardian Name _____
Parent/Guardian Signature _____ Date _____

Appendix B (cont.) Cleveland State University Youth Program/Camp Parent/Guardian Authorization, Waiver and Consent for Self-Administration of Prescription Medication Form

PROGRAM/CAMP INFORMATION

Program/Camp Name: _____(hereafter "Program")

Date(s): _____Time(s): _____Location: _____

PARTICIPANT INFORMATION

Participant Name: _____(hereafter "Participant")

Parent(s)/Legal Guardian(s) Name (if applicable): _____

This form must be completed fully in order for participants to self-administer required medication. A new medication administration form must be completed for each Program attended by the participant, for each medication, and each time there is a change in dosage or time of administration of a medication. Self-medication requires licensed health care authorization and signature, and parent signature

_____ No, my child does not need to take any prescription medication while at the Program.

_____ Yes, my child will need to take prescription medication while at the Program.

All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at camp by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the participant will be attending the Program.

PRESCRIBER AUTHORIZATION

FOR SELF ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name: _____ Dose: _____

Condition for which medication is being administered: _____

Specific Directions (e.g., on empty stomach/with water, etc.): _____

Time/frequency of administration: _____

If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: _____

Medication shall be administered from (date): _____

Special Storage Requirements: _____

Is the participant capable of self-managed care: YES NO

Prescriber's Name/Title: _____

Prescriber's Place of Employment: _____

Telephone: ( ) _____ Fax: ( ) _____

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber's Signature: _____ Date: _____

I/We authorize and recommend self-medication by my child for the above medication. I/We also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I/We shall indemnify and hold harmless the Program Staff, the State of Ohio, Cleveland State University, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors,

employees and agents against any claims that may arise relating to my/our child's self-administration of prescribed medication(s). I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced Program.

Parent/Guardian Name _____
Parent/Guardian Signature _____ Date _____

Parent/Guardian Name _____
Parent/Guardian Signature _____ Date _____