## PROSPECTS ACADEMY
## OVER THE COUNTER MEDICATION AUTHORIZATION & CONSENT

| STUDENT & PARENT/GUARDIAN INFORMATION | | | |
|---|---|---|---|
| **Student Name:** | _____ | **Grade:** | _____ |
| **Parent/Guardian:** | _____ | **Phone:** | _____ |

### AUTHORIZATION

I authorize the Prospects Academy Athletic Trainer and/or designated Prospects Academy staff member to administer the OTC medications checked below to my child for minor, temporary symptoms during the school day or athletic activities. Medication must be provided in its original, properly labeled container. Staff may decline administration or seek medical evaluation when appropriate.

| | | | |
|---|---|---|---|
| ☐ Acetaminophen (Tylenol) | ☐ Ibuprofen (Advil/Motrin) | ☐ Antacid (e.g., Tums) | ☐ Diphenhydramine (Benadryl) |
| ☐ Other: _____ | ☐ See special instructions below | | |

**Medication restrictions / allergies / special instructions:**

_____

### CONSENT & SIGNATURES

I certify that I am the parent/legal guardian and have authority to provide this consent. I have provided accurate information regarding my child's allergies, medical conditions, medication restrictions, and other relevant health information. I understand medication administration does not replace medical care. This authorization remains valid for the current school year unless revoked in writing.

| | | | |
|---|---|---|---|
| **Parent/Guardian Signature:** | _____ | **Date:** | _____ |
| **Printed Name:** | _____ | **Best Contact #:** | _____ |

### MEDICATION ADMINISTRATION LOG — PROSPECTS ACADEMY USE

| Date | Time | Medication | Dose | Reason / Symptoms | Staff Initials |
|---|---|---|---|---|---|
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