

OVER-THE-COUNTER MEDICATION – PARENT/GUARDIAN AUTHORIZATION FORM

↓ To be completed by parent/guardian.
 ↓ Must be completed for each occurrence
 ↓ For trips of three nights or more, also completes the Girl Health Record Form.
 ↓ Please note: This form does not give an adult permission to administer medications of any kind.

Give completed form to Troop/Group Leader or Event Facilitator/Coordinator.
 Forms are not transferrable between events/trips.
 A new form must be submitted for each event/trip participant will be attending.

Participant Information			
Name (Last, First, Initial)	Parent/Guardian	Troop/Group#	Age
Address	City	ST	Zip
Home Phone	Work Phone	Cell Phone	
Licensed Physician's Name and Phone Number (Required)	Name	Phone	
Medical Information:			
<ul style="list-style-type: none"> Please complete all information for each medication sent. All medications need to be in the original containers listing specific dosages and directions on the label/box. The Troop/Group First Aider will hold on to all medications with the exception of an inhaler or Epi-pen. Any time medical assistance including the disbursement of medications is provided to a girl, the responsible adult or certified First Aider must record specifics of the treatment in the <i>First Aid Treatment Log</i> (available in the Resource and Form Library at www.gsofct.org). 			

	Medication	Quantity Sent	Dosage	Frequency	Special Instructions (i.e. given with food)	Possible Side Effects	Storage Requirements
1							
2							
3							
4							
5							

GSOFACT requires that any over-the-counter or prescribed medications should be in the original container and **administered by the girl** in the prescribed dosage in the presence of the responsible adult as per written instruction by custodial parent, guardian, or physician. In some instances, there may be a need to have a certified First Aider administer medication.

GSOFACT's adult members are **not permitted** to administer medication. This **includes** the administration of an Epi-Pen (epinephrine).

If a circumstance arises that causes my Girl Scout to be **unable to self-administer** needed non-prescription medication, I give permission for the certified First Aider to administer the listed non-prescription medication as instructed above.

Signature of Parent/Guardian: _____ Date _____
 (Original signature required)