

First Presbyterian Church Permission to Treat Form

Name _____
Address _____

Parent/Guardian Name _____
Address (if different from youth) _____

Telephone# _____ (home) _____ (work or cell)

Medications Currently Taking

Please list ALL medication (including over-the-counter or nonprescription drugs) taken routinely. Medications must be in original packaging that identifies the prescribing physician (if applicable), the name of the medication, the dosage, and the frequency of administration. All medications (with the exception of asthma inhalers) will be kept in a secure location and administered by the youth leader.

_____ This person takes NO medications on a routine basis.

_____ This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Please attach additional pages for more medications.

I hereby give permission for First Presbyterian Church to administer the above noted medication(s) as specified.

Signature of Parent /Guardian Date

Permission to Treat with Over-the-Counter Medications

I hereby give permission for First Presbyterian Church to administer the following over- the- counter medications if the youth leader in charge deems it necessary. Dosages will be administered according to directions on the package unless a physician directs otherwise.

Medication	Yes	No	Medication	Yes	No
Tylenol (Acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>	Suphedrine (decongestant)	<input type="checkbox"/>	<input type="checkbox"/>
Advil (Ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>	Robitussin DM (cough suppressant)	<input type="checkbox"/>	<input type="checkbox"/>
Cort-Aid (hydrocortisone ointment)	<input type="checkbox"/>	<input type="checkbox"/>	Immodium AD (for diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>
Benadryl (antihistamine)	<input type="checkbox"/>	<input type="checkbox"/>	Neosporin (antibiotic ointment)	<input type="checkbox"/>	<input type="checkbox"/>
Tums (antacid)	<input type="checkbox"/>	<input type="checkbox"/>	Calamine Lotion (for poison ivy)	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent /Guardian Date