



Health

AUGUSTA UNIVERSITY

Athlete's Name: _____

Date of Birth: _____

I _____ (parent/guardian) give Ashle Cooper, MAT, ATC, Georgia Regents Sports

Medicine Center permission to provide over the counter medications to my child

_____ in recommended doses based on package instructions or consultation

with a physician. Over the counter medications may include Ibuprofen (Advil), Acetaminophen (Tylenol),

Diphenhydramine (Bendaryl), Pseudoephedrine (Sudafed), Cetirizine (Zyrtec), Bismuth (Pepto-Bismol), Loperamide HCl

(Imodium). In an emergency situation, I authorize Ashle Cooper, MAT, ATC to utilize an Epi-pen on my child.

My child has drug, food, insect &/or allergies: _____ yes _____ no

If yes, please list them below:

Parent/Guardian Name PRINT

Parent/Guardian SIGNATURE

_____ This authorization is valid until July 31, 2018

Today's Date