OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

Skater Name _____
(Printed)

Skater Birth Date _____ **Skater Age** _____ **Skater Weight** _____

Parent/Guardian Name _____
(Printed)

Parent/Guardian Cell Phone _____

OVER THE COUNTER (OTC) MEDICATIONS

Check the medication(s) the above skater may receive once if deemed necessary and administered by a Findlay Silver Blades Figure Skating Club Board of Director or Coach. Over the Counter Medications will be administered per label instructions based on age/weight.

AVAILABLE FOR SKATERS 12 YEARS AND OLDER

- □ Acetaminophen (Tylenol)
- □ Ibuprofen (Advil/Motrin)
- □ Antacids (Tums)

AVAILABLE FOR SKATERS 6 YEARS AND OLDER

- □ Antihistamine (Zyrtec/Claritin)

AVAILABLE FOR ALL SKATERS

- □ Antibiotic Ointment (Neosporin)
- □ Anti-Itch Cream
- □ Antiseptic

ALLERGIES

- □ Skater is allergic to latex
- □ Skater is allergic to adhesives

Other Allergies _____

_____

_____

_____

The above over-the-counter medications are the only medications stocked by the Findlay Silver Blades Figure Skating Club but are not guaranteed to be always stocked. Findlay Silver Blades Figure Skating Club Board of Directors and Coaches are not able to administer over-the-counter medications contrary to the label directions based on age/weight or prescription medications.

I, _____, give permission for the skater stated above to use the
(Parent/Guardian Printed Name)

over-the-counter medications indicated above. By this permission, I voluntarily, on behalf of my child named above and myself, release the Findlay Silver Blades Figure Skating Club, the Board of Directors and the Coaches from any and all liability for civil damages arising out of or from the administration or failure to administer any medications above. I further understand this permission remains in place until either June 30th of each skating season or until I provide written documentation requesting otherwise.

Parent/Guardian Signature _____ Date _____

Revised 10/31/2023