

**BANDERA INDEPENDENT SCHOOL DISTRICT ATHLETIC
DEPARTMENT
ORAL MEDICATION RELEASE FORM**

The following medications are kept in the Athletic Trainer’s office to help control minor problems (headaches, colds, upset stomach, etc.). Please check which medications you will allow, or not allow your son/daughter to be administered.

I hereby give my permission for the following medications to be given to my son/daughter_____. These medications may be administered by the Team Physician, Athletic Trainer, and/or Coach as necessary to keep the student in optimum health and maintain health and to maintain maximum school performances. Please circle Yes or No for each medication listed below. If you have a question about any of the items below, call the Athletic Trainer.

- | | | | |
|------|--|-----|----|
| I. | Electrolyte supplements | | |
| | 1. Electrolyte Drink – Powerade, Gatorade, etc. | Yes | No |
| | 2. Medilyte and/or Electrol, Heat Guard, Fosfree | Yes | No |
| II. | Analgesic/Anti-inflammatories | Yes | No |
| | 1. Acetaminophen (Tylenol) | Yes | No |
| | 2. Ibuprofen (Advil) | Yes | No |
| | 3. Naproxen Sodium (Aleve, Aleemed) | Yes | No |
| | 4. Topical analgesics (Theragesic, Biofreeze) | Yes | No |
| | 5. Pain-off (contains aspirin and acetaminophen) | Yes | No |
| | 6. Cramp-tabs (contains acetaminophen) | Yes | No |
| III. | Antacids/Anti-Nausea/ & Diarrhea (tablets and liquid) | Yes | No |
| | 1. Alcalak antacids (Tums, Maalox, Rolaids) | Yes | No |
| | 2. Kaopectate/Dimode/Immodium AD | Yes | No |
| | 3. Femetrol | Yes | No |
| | 4. Pepto-Bismol | Yes | No |
| | 5. Nausatal | Yes | No |
| IV. | Nasal/Sinus Decongestant/Cold Medication | Yes | No |
| | 1. Decoral Forte/Tylenol Cold | Yes | No |
| | 2. Chloraseptic/Sepesoothe | Yes | No |
| | 3. Guaicon-MD/ Robitussin-DM | Yes | No |
| | 4. Medikoff (Cough) Drops | Yes | No |
| | 5. Murine/Visine Eye Wash | Yes | No |
| V. | Antihistamines/Sting relief/Antiseptics | Yes | No |
| | 1. Diphen/Benadryl | Yes | No |
| | 2. Sting relief swabs | Yes | No |
| | 3. Triple antibiotic, Germatan, Betadyne | Yes | No |
| VI. | Other medications deemed necessary and/or prescribed by a physician. | | |
| | Comments _____ | | |

Parent/Guardian Signature

Date