Grand Blanc High School Robotics Team
Over-the-Counter Medication Authorization Form

Permission form for administration of over-the-counter medication(s)
2020-2021 VEX Season

A Head Mentor or School Liaison of the Grand Blanc High School Robotics Team will has my permission to administer the following over-the-counter Medication to my child at any official or non-official Team Events.

Generic Medicine Name	Distribution Permitted	
Acetaminophen (Tylenol)	Yes	No
Ibuprofen (Motrin)	Yes	No
Antacids (Tums or Rolaids)	Yes	No
Antihistamine (Benadryl)	Yes	No
Bismuth Liquid or Tablets (Pepto-Bismol)	Yes	No
Loperamide (Imodium)	Yes	No
Cough Drops	Yes	No
Eye Drops (Visine)	Yes	No
Antibiotic Ointment (Neosporin)	Yes	No

I understand any medication will be given at the request of my Student, using the directions indicated on product packaging, based on my child's age and weight, where necessary.

I understand that if my student requires a different over-the-counter medication than those listed above, I will be required to provide such medication to the Grand Blanc High School Robotics Team's School Liaison or Head Mentor, in its original container.

Student Last Name: _____

Student First Name: _____

I have read and understand the Grand Blanc High School Robotics Team Medical Authorization form, and by signing this document agree that the over-the-counter medications indicated above may be distributed to my Student.

Printed name of Parent/Legal Guardian: _____

Parent or Legal Guardian Signature: _____ Date _____