

**BHSU DAKOTA DREAMS SUMMER CAMP: JUNE 26-31**  
**PARENT/GUARDIAN CONSENT FOR OVER-THE-COUNTER MEDICATION FORM**

By my signature below, as parent(s) or guardian(s) of \_\_\_\_\_ (“the Participant”), and on behalf of the Participant and the Participant’s heirs, next of kin, successors in interest, assigns, personal representatives, and agents, and as consideration for Participant’s ability to engage in the following Activity entitled, \_BHSU Dakota Dreams Summer Camp\_, hosted by \_BHSU\_, and held at \_BHSU, WDT, SD Mines, & Black Hills Region\_, on the property of BHSU, I do hereby:

1. Authorize Program Staff of the Activity to administer the following non-prescription (over-the-counter) medications (initial all that apply):

_____ All of the below medications	_____ No over-the-counter medications	
_____ Allergy/antihistamine medication	_____ Cold medication	_____ Cough syrup
_____ Ibuprofen	_____ Acetaminophen	_____ Antacid
_____ Kaopectate/generic concentrate	_____ Milk of Magnesia	_____ Sore throat lozenge
_____ Hydrocortisone cream	_____ Benadryl cream	_____ Antibiotic cream
_____ Tincture of Benzoin (helps tape adhere)	_____ Burn gels	_____ Sunscreen
_____ Eye drops for dryness/redness	_____ Antifungal cream	

Any of the following over-the-counter medications: \_\_\_\_\_  
\_\_\_\_\_

2. Declare the following to be the complete and accurate list of medications to which Participant is allergic, as well as the type of reaction Participant may suffer for each: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Further declare the following to be over-the-counter medication that Participant takes on a regular basis: \_\_\_\_\_  
\_\_\_\_\_

4. Acknowledge and agree that any authorized over-the-counter medications will be given only at the manufacturer’s recommended dosage and only where the medication is available to the program staff of the Activity. I further understand and agree that program staff reserve the right to use generic equivalents of the above medications if available.

5. **Waive, release, and forever discharge any claim, cost, loss, damages, liability, or expense, including attorney’s fees, by Participant or I against the State of South Dakota, South Dakota Board of Regents, BHSU, and their officers, employees, agents, and volunteers (hereinafter, “Releasees”), and indemnify and hold harmless Releasees from any cause of action arising from the Participant being administered the above indicated over-the-counter medications, unless the liability is the result of Releasees’ sole negligence or willful misconduct.**

*Additionally, by my signature below, I aver reading this Consent for Over-the-Counter Medication Form in full, completely understanding its terms and that I am accurately providing all information solicited above. I, the undersigned parent and/or legal guardian, with full authority to bind, am freely signing this agreement.*

**Parent/Guardian**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_