



Over-The-Counter Medication Consent Form

The following medications may be given according to directions provided by the manufacturer unless otherwise specified below. These medications will be used to address the symptoms/medical conditions for which the manufacturer intended. Brand names given may be replaced with generic equivalents. This consent form is valid for one year.

Client's Name: _____ **DOB:** _____

Anti-inflammatory, Pain, Fever

Midol Menstrual Complete (females only)
Ibuprofen (not to be given if on Lithium)
Acetaminophen (Tylenol) 325 mg
- OR -
Acetaminophen extra strength 500 mg

Anti-Fungal

Lamisil

Cold, Cough, Allergy

Benadryl
Sudafed (pseudoephdrine)
Guaifenesin
Dextromethorphan

Gastrointestinal

Milk of Magnesia
Tums
Zantac
Lactaid

Ears, Nose, and Throat

Chloraseptic Spray (Sore Throat)
Chloraseptic Lozenges
Saline Nasal Spray

Eye Care

Baush and Lomb Eye Wash

Skin Care

Gold Bond Powder
Hydrocortisone Cream
Bacitracin antibiotic ointment
Triple antibiotic ointment

Miscellaneous

Epson Salt
RID (Lice Treatment)

Other (Must be Specified) _____

If consent for one of the above over-the-counter medications is *not given*, please specify the medication and indicate why it is not to be used.

Signature of Parent/Legal Guardian: _____ Date: _____

Physician Approval Date: _____ Date: _____
Signature Printed Name