Bancroft

Over-The- Counter (OTC) Medication Order Form

P&A Children's Transitional Campus/Lindens Programs Ages 12 years and Above

Name: _____ DOB: _____ Date: _____

Weight: _____ Allergies: _____

Current Medications: _____

Please initial **"Yes"** in the corresponding space provided for all medications you wish to provide or **"No"** in the corresponding space provided, to each medication you do not wish to provide.

Please do not use this form for other prescription medications.

Symptom(s)	Medication, Dosage and Specific Instructions	Physicians Initials	
		Yes	**No**
Headache, Minor Pain	**Acetaminophen (Tylenol)** 325mg- two (2) tablets (650mg) by mouth every four (4) hours as needed. Maximum Dose- 6 in 24 hours. Call MD with pain that continues for 24 hours.		
		Yes	**No**
Muscle Aches	**Ibuprofen (Advil, Motrin)** 200 mg two (2) tablets (400mg) by mouth every six (6) hours as needed for 3 days. Maximum Dose-4 in 24 hours. Take with food or milk. For stomach issues, consult MD prior to administering.		
		Yes	**No**
Fever 100.0 °F or higher (by mouth)	**Acetaminophen (Tylenol)** 325mg- two (2) tablets (650mg) by mouth every four (4) hours as needed. Maximum Dose- 6 in 24 hours. Call MD with fever longer than 24 hours. Notify MD for any fever greater than 101.5° F.		
		Yes	**No**
Cuts, Abrasions, and Scratches	Wash with soap and water, dry thoroughly then apply **Polysporin or generic equivalent antibiotic ointment** to a dry, sterile dressing or band-aid. Apply twice (2) per day, up to three days or until healed. Maximum dose 2 in 24 hours. Consult MD immediately if wound becomes reddened, swollen or oozes, or for temperature 100.0° F or if symptoms persist greater than 7 days.		
		Yes	**No**
Cough	**Guaifenesin (Robitussin)** cough syrup- two (2) teaspoons every four (4) hours as needed. Maximum of 6 doses in 24 hours. If cough persists for more than 3 days or if temperature of 100.0° F or higher notify MD. **With history of asthma, call MD before giving cough syrup.** **For diabetic patients, use sugar-free mixture.**		
		Yes	**No**
Dry Skin	**Hydocerin (Eucerin)** cream three (3) times per day to dry skin until resolved. Maximum dosage, see directions on bottle. If dry skin persists longer than 2 weeks notify MD.		
		Yes	**No**
Stuffy Nose	**Ocean Nasal spray or generic equivalent**-Spray two (2) sprays in each nostril three (3) times a day. Maximum dose 3 in 24 hours. Call MD with no improvement.		
		Yes	**No**
Menstrual Cramps (Females Only)	**Ibuprofen (Advil, Motrin)** 200 mg two (2) tablets (400mg) by mouth every six (6) hours as needed for cramps up to 3 days. Maximum Dose-4 in 24 hours. Take with food or milk. For stomach issues consult MD for stomach issues.		
		Yes	**No**
Itching Due to Insect Bite	**Diphenhydramine (Benadryl)** 25 mg tablet- one (1) tablet by mouth every six (6) hours as needed for itching. Maximum dose four (4) in 24 hours. Wash area with cool water and apply cool compress or ice.		

	Notify MD immediately if welts, swelling or severe itching occurs.		
Symptom(s)	**Medication, Dosage and Specific Instructions**	**Physicians Initials**	
Sun Exposure	**Sunscreen SPF 30 or greater**- Apply to all exposed skin surfaces prior to activities. Reapply as needed according to the Manufacture's directions.	**Yes**	**No**
Groin Rash	**Blamex** -Apply to perineal and/or buttock area 3 times a day as needed for redness. Maximum dose 3 in 24 hours. Notify MD for any breaks in skin or persistent rashes.	**Yes**	**No**
Exposure to outdoor insects (i.e. mosquitoes, ticks)	**Insects repellant containing DEET (10% or Less) Picaridan or Oil of Eucalptus.** Apply to exposed skin or clothing prior to outdoor activities in grassy or wooded areas. Avoid face or any cuts or scratches on skin.	**Yes**	**No**
Plan of Care		**Yes**	**No**
Vomiting	Clear liquids as needed for vomiting. After 1st episode of vomiting nothing by mouth for one hour; then offer small amounts of clear liquids and advance as tolerated. Notify MD if persistent vomiting lasting longer than 12 hours.		
Diarrhea	BRAT Diet-(**B**anana, **R**ice, **A**pplesauce, **T**oast) for one day of diarrhea (more than 2 loose bowel movements in 8 hours). Notify MD if diarrhea is associated with fever (100.0 °F or higher), bloody bowel movement, or more than 4 loose bowel movement in 24 hours.	**Yes**	**No**
Additional Over-The-Counter Medications		**Yes**	**No**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

All orders are valid for one year from the signature, unless discontinued by subsequent physician order.
Physician's printed name and address are required.

Printed Name: _____

Physicians Signature/Initials: _____ Date: _____

Address: _____

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Physician Comments/Notes: _____

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