Prescription for Over-the-Counter (OTC) Medications (PRN)

☐ Placement ☐ Annual Date of Placement: _____

Child's Name: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Allergies: (food, medication, venom, etc.) _____

_____

_____

List All Current Medications:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

*Community Care Licensing Regulations (**Title 22-80075 & 83075**) require Foster Parents to have prior approval from a physician before they can administer any over-the-counter medication. Your assistance in having the physician prescribe specific medication in each of these categories for the child named above, will be appreciated. Any categories not checked will require phone and/or office contact with the physician prior to administration of any over-the-counter medication.*

In each category, please CHECK the medication(s) which you are prescribing, CIRCLE either the tsp, tab, or mgs., and INDICATE the amount and frequency which you prescribe for the child.

I. ANALGESICS & ANTIPYRETICS (for pain relief and fever control)

Acetaminophen:

☐ Generic ☐ Tylenol ☐ Liquiprim ☐ Panadol ☐ Other: _____

_____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

Ibuprofen:

☐ Generic ☐ Motrin ☐ Advil ☐ Other: _____

_____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if the fever persists for more than 24 hours, or is greater than _____ degrees or if:

II. COUGH PREPARATIONS

☐ Generic ☐ Robitussin DM ☐ Triaminic DM ☐ Vicks Pediatric Formula 44 ☐ Other: _____

_____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

III. DECONGESTANTS: (for congestion or stuffy nose)

☐ Generic ☐ Sudafed ☐ Dimetapp ☐ Robitussin CF ☐ Triaminic ☐ Other _____

_____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

IV. ANTIHISTAMINES: (for skin and nasal allergy symptoms)

☐ Generic ☐ Allarest ☐ Comtrex ☐ Vicks Pediatric Formula 44 ☐ Actifed Preparations

☐ Dimetapp Preparations ☐ Benadryl Preparations ☐ Other: _____

_____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

V. SORE THROAT PREPARATIONS:

☐ Generic ☐ Cepacol ☐ Chloraseptic ☐ Halls Lozenges ☐ Sucrets ☐ Other: _____

_____ tsp/tab/sprays every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

CHILD'S NAME:

VI. TOPICAL SKIN PREPARATIONS: (for rashes, eczema, scabies, etc.)

☐ Generic ☐ Cortizone 5 ☐ Cortaid ☐ Bactine ☐ Mycltracin

☐ Neosporin ☐ Other: _____

Apply _____ times a day. Not to exceed _____ doses in 24 hrs.

Recontact doctor if: _____

Topical Skin Preparations: (for athletes foot, diaper rash, yeast infection on skin)

☐ Generic ☐ Desitin ☐ Curex ☐ Lotrimin ☐ Other: _____

Apply _____ times a day. Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

VII. LICE TREATMENT: (read the package prior to administering treatment)

☐ Generic ☐ Nix ☐ Rid ☐ Other: _____

Apply _____ times a day. Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

VIII. MULTIVITAMINS:

☐ Generic ☐ Centrum ☐ One a Day ☐ Flintstones ☐ Other: _____

_____ tsp/tab/mgs _____ times a day Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

IX. ANTI-DIARRHEAL:

☐ Generic ☐ Kaopectate ☐ Pepto-Bismol ☐ Other: _____

_____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if diarrhea continues more than 24 hours or if:

X. ORAL REHYDRATION SOLUTIONS: (for vomiting/diarrhea):

☐ Generic ☐ Pedialyte ☐ Other: _____

_____ oz.s every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if vomiting continues more than 24 hours or if:

XII. OTHER MEDICATIONS:

☐ _____ _____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

☐ _____ _____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

☐ _____ _____ tsp/tab/mgs every _____ hrs. Not to exceed _____ doses in 24 hrs.

Recontact doctor if:

_____ _____

Physician's Name (please print) *Physician's Phone*

_____ _____ _____ _____

Physician's Address: Street *City* *State* *Zip Code*

This prescription is good for one year from the date signed.

_____ _____

Physician's Signature *Date*