Over The Counter Medication Approval

Patient name: _____

Please indicate by checking the space provided, if your patient may have on hand and use these medications for common ailments. Form expires one year from date of signature.

Drug/Product	May Use	May **Not** Use	**Description for Use**
Acetaminophen			As directed on label for pain, headache, or fever
Ibuprofen			As directed on label for pain, headache, or fever
Naprosyn/Anaprox			As directed on label for pain, headache, or fever
May use the above for up to 3 consecutive days. Notify doctor if needed on day 4			
Pseudophedrine			As directed on label for sinus congestion
Allergy Capsules Diphenhydramine HCL			As directed on label for runny, itchy, nose, sneezing, scratchy throat, itchy/watery eyes
Antacid/Antiflatulent			As directed on label for indigestion, stomach upset, excess gas
Calcium Carbonate			As directed on label for heartburn
Do not use antacid within 1 hour of administering psychotropic medication			
Anti-diarrhea			As directed on label after loose bowel movement
Cough syrup			AS directed on label for cough/congestion
Cough drops			As directed on label for cough
Ipecac syrup			As directed on label
Calamine lotion			As directed on label for poison ivy, poison oak, poison sumac
Anti-Itch cream/spray			Apply to affected area as directed on label, **do not use on broken skin**
Desenex powder			As directed on label fro Athlete's foot
Sunscreen lotion			As directed on label before exposure to sunlight
Sunburn lotion/cream			As directed on label for sunburn
Hydrogen Peroxide			As directed on label for cuts, scrapes
First Aid spray			As directed on label for cuts, scrapes
Triple Antibiotic ointment			As directed on label for cuts or scrapes and cover with dry sterile dressing if needed. **Notify Dr of redness or swelling**
Warm/Cold Packs			Apply to affected/painful areas as needed
Fluoride Rinse			As directed on label
Stool Softener			As directed on label if no bowel movement in ___days
Laxative			As directed on label, if no bowel movement in ___days
Milk of Magnesia			As directed on label, if no bowel movement in ___ days
Dandruff shampoo			As directed on label

Physician's Signature_____Date_____

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