DOUGLASS CHILD STUDY CENTER

OVER-THE-COUNTER MEDICATION ADMINISTRATION AUTHORIZATION

Dear Physician:
Please indicate the medications you authorize for _____. In the event that any medication is needed at the Child Study Center, parents will also authorize medication administration. No medication will be dispensed without prior physician and parent authorization.

❑ Acetaminophen (Tylenol/Tempra)	_____cc/tsp/mg per 4 hours prn
❑ Benadryl/diphenhydramine	_____tsp/mg per 4-6 hours prn
❑ Dimetapp/Dimetapp DM	_____tsp per 6 hours prn
❑ (infant decongestant drops)	_____dropper(s) per 6 hours prn
❑ Ibuprofen (Motrin/Advil)	_____tsp/mg per 6 hours prn
❑ Mylicon	_____dropper(s) prn
❑ Orajel	_____apply to gums prn
❑ PediAcare (infant-decongestant)	_____dropper(s) per 4-6 hours prn
❑ (infant-decongestant/cough)	_____dropper(s) per 4-6 hours prn
❑ Robitussin/DM/CF	_____tsp per 4-6 hours prn
❑ Triaminic	_____tsp per 6 hours prn
❑ _____	_____tsp/mg ___times/day prn
❑ _____	_____tsp/mg ___times/day prn
❑ _____	_____tsp/mg ___times/day prn
❑ Albuterol (via nebulizer)	_____amp/mL ___times/day
❑ Cromolyn (via nebulizer)	_____cc/ns
❑ Ointment(s): _____	_____apply to skin prn
❑ Other: _____	_____tsp/mg/gtts ____times/day prn
❑ Other: _____	_____tsp/mg/gtts ____times/day prn
❑ Other: _____	_____tsp/mg/gtts ____times/day prn

Comments: _____
_____
_____
_____
_____

Physician's Signature: _____ Date:_____

Print Physician's Name: _____

Parent/Guardian Signature: _____ Date: _____