

## Physician's Order for Over the Counter Medications

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergies: \_\_\_\_\_

Physician Name: \_\_\_\_\_ (please print) \*

The policy for over the counter (OTC) medication administration is according to the North Carolina Division of Health Service Regulation. All OTC medications must be kept in a secured place for dispensing when needed by the consumer for self-administration. Generic equivalents may be used.

All medications that are given to the consumer must be accompanied by a signed Medication Order Form from the physician and be in the original container.

The First Step Farm appreciates your cooperation and asks that you contact the Program Director or Executive Director if you have any questions regarding any aspect of these policies.

### **Check Medication if OK to give to consumer while at the First Step Farm.**

#### **For headache/fever/burns/earache/muscle aches/pain/menstrual cramps:**

\_\_\_\_\_ Acetaminophen (like Tylenol)      \_\_\_\_\_ Ibuprofen (like Advil, Midol, Motrin)  
\_\_\_\_\_ Naproxen (like Aleve)

#### **For sore throat:**

\_\_\_\_\_ Throat lozenges (Sucrets)      \_\_\_\_\_ Sore throat spray (Cepacol)

#### **For mild allergic reactions:**

\_\_\_\_\_ Diphenhydramine (like Benadryl)

#### **For cold symptoms:**

\_\_\_\_\_ Guaifenesin (like Mucinex)      \_\_\_\_\_ Medicated Cough Drops

\_\_\_\_\_ Decongestant and cough suppressant (Alka Seltzer plus cold and cough, Tylenol Cold & Flu, Theraflu, Advil Cold & Sinus, Dayquil, etc)

#### **For upset stomach:**

\_\_\_\_\_ Antacid/antigas (like Tums, Mylanta, Pepto bismol)

#### **For minor skin irritations (cuts, sores, stings, rashes):**

\_\_\_\_\_ Antibiotic ointment      \_\_\_\_\_ Anti-itch gel

#### **For constipation:**

\_\_\_\_\_ Bulk-forming (Metamucil)      \_\_\_\_\_ Stimulant (Ex-lax, Senekot)

#### **For nutritional supplementation:**

\_\_\_\_\_ Vitamins and minerals (including multivitamin, B, C, D, E, Calcium, Magnesium, Fish Oil, etc.)

\_\_\_\_\_  
**Signature of Physician\***

\_\_\_\_\_  
DATE

\_\_\_\_\_  
**Signature of consumer/resident**

\_\_\_\_\_  
DATE