PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS

Name________________________________ Age__________ Date_______________

	Brand Name	Amount	Parent Authorization
1. Sunscreen			
2. Diaper cream			
3. Insect bite treatment			
4. Insect repellent			
5. Burn/Scratch Spray			
6. Congestion			
7. Fever			
8. Diarrhea			
9. Vomiting			
10. Upset stomach			
11. Headache			

Permission to administer over the counter medication when needed or when verbal authorization is given to licensed provider ________________________________for my child ________________________________.

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Parent's signature

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Physician's signature

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Date

To be updated as needed. Weight change varies dosage amounts.