KEEPING KIDS SAFE, INC.

OVER THE COUNTER MEDICATION

Child's Name: _____ Child's D.O.B._____

This form is to be completed by a physician to guide the foster parents correct dosage of OTC (Over the Counter) medication they can administer to a child. Please provide a copy of this form to the agency.

DRUG NAME	SYMPTOM	YES or NO	DOSAGE
Tylenol	discomfort / fever		
Advil	discomfort/ fever		
Throat Lozenges	throat irritation/cough		
Benadryl	allergies		
Chloraseptic Spray	throat irritation		
Nyquil / Dayquil	discomfort / fever		
Robitussin	cough		
Milk of Magnesia	constipation		
Imodium	diarrhea		
Mylanta	stomach upset		
Tums	heartburn/stomach upset		
Sudafed	nasal & sinus congestion		

Physician's Name: _____

Physician's Signature_____ Date_____