Fremont County Department of Human Services
Kinship/Foster/Adoptive Program

Over-The-Counter Medication Authorization
Per Regulation 7/708.41 (J3) and 7.714.81 (J3)

Child's Name:_____ **DOB:**_____

As a foster parent, I am unable to dispense any medication unless prescribed in writing by a physician. This form includes a list of over-the-counter medication such as pain relievers, cough syrup, diaper rash ointment, etc. Please complete this list.

Aspirin Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

Acetaminophen Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

Motrin Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

Decongestant Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

Expectorant Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

Diaper Rash Ointment Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

Cold Syrup Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

First Aid (minor wounds) Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

Baby Powder Yes[ ] No[ ] Recommended Brand:_____
Dosage:_____ Needed:_____

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Antacids Yes[ ] No[ ] Recommended Brand:_____

Dosage:_____ Needed:_____

Cough Syrup Yes[ ] No[ ] Recommended Brand:_____

Dosage:_____ Needed:_____

Other:_____ Yes[ ] No[ ] Recommended Brand:_____

_____

Dosage:_____ Needed:_____

List any prescription medications authorized:_____

_____

Verbal Permission from Medical Provider to Administer Over the Counter Medication:

Name of Provider:_____ Date:_____

Medication/Brand:_____

Dosage:_____ Needed:_____

_____ _____

Physician or Medical Provider Date

_____ _____

Parent/Legal Guardian Date

Refusal to Sign:

_____ _____

Physician or Medical Provider Date

cc: Child's File