OVER THE COUNTER MEDICATION FORM

Client/Patient Name: _____ DOB: _____

STANDING ORDERS FOR OVER THE COUNTER MEDICATIONS		
MEDICATION	**TREATMENT GOALS**	**STRENGTH**
Allergy and Cold Preparations	For relief of allergy or cold symptoms	As dispensed OTC
Kaopectate concentrate or Generic	For relief of loose bowel movements	As dispensed OTC
Milk of Magnesia or Generic	For relief of Constipation	As dispensed OTC
Tylenol or Generic	For relief of minor aches & pains, and /or fever	As dispensed OTC
Ibuprofen or Generic	For relief of minor aches & pains, and /or fever	As dispensed OTC
Benadryl or Generic.	For relief of allergy symptoms	As dispensed OTC
Multivitamin and Nutrition Supplements	Food Supplement	As dispensed OTC
Cough and Cold preparation	For relief of cold and cough symptoms	As dispensed OTC

Comments:

Read Carefully:
By my signature below, I acknowledge that during my participation in the First at Blue Ridge, Inc. residential treatment program, I will take only take those over-the-counter medications listed above. Further, *I agree only to take recommended doses and for the indicated uses on the over-the-counter medication packages. I recognize that it is my responsibility to review the package information, with each dose taken, for any potential adverse interactions and contraindications to my use*. **Further, I hereby agree to hold First at Blue Ridge Inc., and the healthcare provider listed below harmless if I take any over the counter medication not listed above or outside the parameters of recommended dosages, uses and warnings or contraindications.**

_____ _____ Date _____
Physician Signature Physician Print

Client's signature _____ Date _____

☆ Even if not on prescription medications ALL forms must be signed. ☆