Able-
SERVICES

Part of the Leg Up Farm Family

HEALTHCARE PROFESSIONAL AUTHORIZATION FOR ADMINISTRATION OF NON-PRESCRIPTION/OVER-THE-COUNTER MEDICATION

*Form can only be completed and signed by a Healthcare Professional

Participant Name: _____ Date of Birth: _____

Medication	Dosage & Time	Condition and/or Symptoms Treated	Possible Side-Effects	Initial if medication is APPROVED for participant
Acetaminophen (Tylenol®)	Administer according to the manufacturer's label	Relief of minor aches and pain	None significant if administered per manufacturers label	
Ibuprofen (Advil® Motrin®)	Administer according to the manufacturer's label	Relief of body aches and pain or menstrual cramps	Stomach upset	
Calcium Carbonate (Tums®)	Administer according to the manufacturer's label	For stomach ache or heart burn	Constipation	
Hydrocortisone 1% Topical Cream	Administer topically according to the manufacturer's label	For relief of itching associated with rashes & inflammation	None significant if administered per manufacturers label	
Triple Antibiotic Ointment (Neosporin®)	Administer topically according to the manufacturer's label	To help prevent infection in minor cuts, scrapes, & burns	None significant if administered per manufacturers label	

Special Instructions: _____

_____

Healthcare Professional Printed Name: _____

Practice Name: _____ Phone: _____

Address: _____

_____

_____ _____

Healthcare Professional's Signature Date