

**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

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