RED MOUNTAIN
FAMILY SERVICES, INC.

Consent for Over the Counter Medicine

This Form is to be updated by a Physician Annually when EPSDT EXAM is done

Client:_____ Age: _____

Date of Birth: _____ SS# _____

The purpose of this form is to confirm approval for over-the-counter medications for the named Treatment Foster Care Child that is admitted in the Red Mountain Family Services, Inc. Treatment Foster Care Program. The medications approved on the list below will be administered as needed. The need will be determined by the Treatment Foster Care Parent.

Approved Please Check	Medication:	Dosage and Frequency as per Manufacturer's direction. Please specify otherwise:	Indication (reason for Medication	Side Effects
	Acetaminophen (Tylenol)		Fever/Pain	
	Ibuprofen (Advil, Motrin)		Fever/Pain	
	Pseudoephendrine (Sudafed)		Nasal Congestion	
	Diphenhydramine (Benadryl)		Nasal Congestion	
	Robitussin DM/Plain		Cough	
	Cough Drops		Cough	
	Pepto Bismol		Upset Stomach/ Nausea	
	Loperamide (Imodium)		Diarrhea	
	Neosporin Ointment		Cuts and Scrapes	
	Bacitracin Ointment		Cuts and Scrapes	
	Sunscreen			
	Other- Please List			

Additional non-prescription medication that can be administered by Red Mountain Family Services that do no require individual standing orders include the following topical medication

Injury/Swelling:
☐ Bengay ☐ Epsom Salts

Contact Dermatitis (Poison Ivy, etc.):
☐ Benadryl Cream ☐ Hydrocortisone Cream

Fungal Rash
☐ Desenex Powder ☐ Tinactin Cream

Menstrual Medication
☐ Midol ☐ Pamperin

_____ _____
TFC Child if over age 12 Date Custody Holder/Parent Date

_____ _____
RMFS Treatment Coordinator Date Physician Signature Date