THE WAYFINDER EXPERIENCE

OTC FORM

STUDENT NAME: _____ PHYSICIAN NAME: _____

DATE of BIRTH: _____ PHONE NUMBER: _____

The following over--the--counter medications can be administered as needed per label instructions by age and weight of the student. PLEASE NOTE: Absolutely NO over--the--counter medications, treatments, or topical ointments can be administered without a physician and parent's signature.

TO THE PROVIDER: Please, indicate approval for administration by circling yes or no in the space indicated.

MEDICATION	ROUTE	DOSAGE	SCHEDULE AND INDICATIONS	MAY BE ADMINISTERED
Tylenol (Acetaminophen)	By mouth (elixir or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Motrin (Ibuprofen)	By mouth (elixir, suspension or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Benadryl (Diphenhydramine)	By mouth (elixir, tablets or capsules)	Per label instructions By age and weight	Every 6 hours PRN allergies, or insect bites	Yes No
Tums (Calcium Carbonate)	By mouth (tablets)	Per label instructions By age and weight	Every 2 hours PRN gastric upset	Yes No
Sunblock or Sunscreen	Apply topically	SPF ≥30	Apply PRN prior to sun exposure	Yes No
Antibacterial Ointment	Apply topically	Appropriate for injury	Apply 1--3x Daily PRN minor cuts	Yes No
Hydrocortisone Cream 1%	Apply topically	Hydrocortisone 1%	Apply 3--4x Daily PRN skin irritation	Yes No
Emergency Eyewash Solution	Ophthalmic Administration	Per label instructions	PRN for foreign body/substance in eye	Yes No

Please Note: This form is not valid without the Provider's Office Stamp.

Provider Signature:_____

Date:_____

Patient/Guardian Signature:_____

Date:_____

_____

Please Stamp Here

_____