## Physician Medication Authorization (Prescriptive & Over the Counter Medications)

Name of Child/Youth:			D	DOB:	
Known Allergies:				None:	
Known Medical Conditions	s:			None:	
Current Medications/Dose	:				
Condition	Yes	No	Recommended Medication	Dosage	
Acne					
Allergies					
Athletes Foot					
Burns Cold Sore					
Cold/Congestion Constipation					
Diarrhea					
Cough Fever					
Insect Bites					
Insect Bites Insect Repellent					
Lice					
Motion Sickness					
Other					
Pain Relief					
Pain/Cramps					
Skin Irritations or					
Rash					
Sunburn					
Teething					
Upset Stomach					
Vitamins & Minerals					
Vomiting					
Physician Signature:			Date:		