CWS-13 (OTC Authorization)
10/16/12

Physician Medication Authorization
(Prescriptive & Over the Counter Medications)

Name of Child/Youth: _____ DOB: _____

Known Allergies: _____ None: ____

Known Medical Conditions: _____ 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 Repellent				
Lice				
Motion Sickness				
Other				
Pain Relief				
Pain/Cramps				
Skin Irritations or Rash				
Sunburn				
Teething				
Upset Stomach				
Vitamins & Minerals				
Vomiting				

Physician Signature: _____ Date: _____