

LoneStar Solutions Foster Care
Over-the-Counter Medication Orders

Child's Name: _____ DOB: _____ Age: _____

Medicaid #: _____ SS #: _____

Today's Date: _____ Physician's Name: _____

Physician's Telephone #: _____

Foster parent(s) and other responsible adults may administer the following over-the-counter medications to this child:

For pain/headache: _____

For reducing fever: _____

For sore throat: _____

For nasal congestion: _____

For coughing: _____

For stomach ache: _____

For diarrhea: _____

For constipation: _____

Other: _____

Should the child take a multi-vitamin/mineral? Yes No

If yes, type or brand: _____

Orders expire on (Date: mm/dd/yy): _____

Physician signature: _____ Date: _____