Name:____ Date:______________

Check which over the counter medication this individual may use as needed:

Please make changes as needed:

Pain or Temperature

_____ **Tylenol (Acetaminophen)** take two 325mg tablets, by mouth, every 4 hours, not to exceed 12 tablets in 24 hours, as needed, for general pain (not including stomach pains), headache, or temperature over 100 degrees Fahrenheit taken by an oral or temporal device

_____ **Other** (describe)____

Laxative

____ **Milk of Magnesia** 30ml by mouth at bedtime, as needed, not to exceed 60cc in 24 hours, give after three days of no bowel movements, to produce a bowel movement. Call RN if medicine does not produce a bowel movement.

_____**Other**____

Cough

_______**Robitussin DM**, 10ml, by mouth, every 4 hours, as needed, for non-productive cough, not to exceed 6 doses in 24 hours, if cough persists for 5 days, without a fever, call MD to make appointment.

______**Other**____

Diarrhea

_____**Imodium AD** 2mg tablets, take 2 tablets (4mg), by mouth, after first loose stool then, one tablet (2mg) after each subsequent loose stool, as needed for loose stools, not to exceed 4 tablets in 24 hours. If loose stools continue despite medication, call MD for appointment.

Other:

______May use **Triple Antibiotic Cream/Ointment** apply to affected area(s) topically three times a day, as needed, for areas of broken skin, if not improved in 7 days call doctor for appointment

Caffeine and Alcohol

_____Individual may consume beverages and/or items containing caffeine.

_____Individual may consume beverages containing alcohol.

_____Additional information:____

____**Other**____

Dietary Guidelines:____

____

Work Limitations:____

____

Physician's Signature:__________________________________Date:_____________