

Over-the-Counter Medication Physician Consent Form

Date: _____

Name: _____

Parent: _____ Daytime Phone: _____

Symptoms:

Medication

Dosage/Direction

Fever		
Cough/Cold		
Headache		
Sore Throat		
Allergies		
Poison Ivy, etc.		
Wounds, sores, etc.		
Cramps		
Other: _____		

Other symptoms and medication allowed:

Doctor Signature: _____

If there is a generic form that is used by your medical facility, you may fax it to:

Chris Feldmann, Office Manager 636-239-1198

Or mail to: Chris Feldmann

1000 Borgia Drive

Washington, MO 63090