Hinge Point Youth Homes -Over-The-Counter Medication Authorization

As a legal representative for _____, I grant permission to Hinge Point Youth Homes/Prosper DDA and those presently employed by either company, to administer over-the-counter medications, mild remedies, and supplements, for the prevention of health concerns and/or the treatment of presenting symptoms reported by and/or observed in the client and which are specifically listed below as being treated by the particular agent and which condition may be causing or would cause discomfort or otherwise interfere with the physical and mental state of my ward. This permission grants authority insofar as the treatments are administered as directed by the product. Any alterations to the administration directions will be authorized and ordered by a physician, nurse practitioner, physician's assistant, or other person licensed for the practice of dosing and prescribing legal and pharmacological treatments. Initial next to each treatment option that you are authorizing. Denote allegies, if appropriate, and do not initial that treatment. Write in any other over-the-counter agents for your ward and initial your authorization.

Initials	Allergic?	Treatment name	For the care of...
	Y / N	**Acetametaphen**	Pain and Fever
	Y / N	**Ibuprofen**	Pain and Fever
	Y / N	**Cold/Flu Medicine**	Cold symptom relief per the symptoms presenting
	Y / N	**Cough Drops**	Mild sore throat and cough
	Y / N	**Immodium or equivalent**	Diarreah
	Y / N	**Mirilax or other laxitive**	Constipation
	Y / N	**Lip Balm**	Dry and cracked lips
	Y / N	**Lotion**	Dry Skin and/or eczema
	Y / N	**Vaseline**	Dry and cracked skin, lubricating needs
	Y / N	**Sunscreen**	UV protection for outdoor activities
	Y / N	**Alovera gel**	Treatment of sunburns
	Y / N	**Saline Eye Drops**	Minor eye irritation
	Y / N	**Terbinafine or equivalent**	Athletes foot and treatment of fungus
	Y / N	**General First Aid supplies**	All treatment options for mild injuries
	Y / N	**Humidifier**	Mild bronchial difficulties from cold symptoms
	Y / N	**Melatonin**	Mild Sleep needs
	Y / N	**Benedryl or equivalent**	Allergic reactions
	Y / N	**Vitamins and Supplements**	Maintenance of health
	OTHER		
	OTHER		

_____ _____

Signature Date

_____ _____

Printed Name Relationship