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# Consent form for OTC Medication

**Name:_____ DOB_____**

**Preferred OTC Medications to be given include:**

**Acetaminophen _____ YES _____ NO**

**Aleve/Advil _____ YES _____ NO**

**Asprin _____ YES _____ NO**

**Ibuprofen _____ YES _____ NO**

**Cough Drops _____ YES _____ NO**

**Other, Please list_____**
**_____**
**_____**

**Comments_____**
**_____**
**_____**

**PCP Signature_____ Date_____**

**Caregiver Signature_____ Date_____**

**Golden Moments Nurse Signature_____ Date_____**