NEW CONNECTIONS
PATHWAYS CAREER SERVICES
CREATING PATHWAYS TO NEW CONNECTIONS

This form is to be completed annually during annual physical examination.

INDIVIDUAL'S NAME: _____

PARENT/GUARDIAN/CONSUMER'S SIGNATURE: _____

PHYSICIAN'S PRINTED NAME: _____ DATE: _____

ALLERGIES: _____

DIAGNOSIS: _____

AUTHORIZATION	MEDICATION	INDICATION	DOSE	
__ Yes __ No	TYLENOL (ACETAMINOPHEN)	fever, headache, menstrual cramps	325 mg tablets; 2 tablets by mouth	every 4-6 hours **PRN**
__ Yes __ No	MOTRIN (IBUPROFEN)	fever, headache, toothache, cramps	200 mg tablets; 2 tablets by mouth	every 4-6 horus **PRN**
__ Yes __ No	ROBITUSSIN (GUIATUSS)	cough, congestion, runny nose	1-2 teaspoons by mouth every 4-6 hours **PRN**	every 4-6 hours **PRN**
__ Yes __ No	KAOPECTATE	diarrhea	1-2 teaspoons by mouth	every 4-6 hours **PRN**
__ Yes __ No	MYLANTA	indigestion, stomach discomfort	1-2 teaspoons by mouth	every 4-6 hours **PRN**
__ Yes __ No	BENADRYL (DIPHENHYDRAMINE)	allergic reaction, allergies	25 mg tablets; 1 tablet by mouth	8 hours **PRN**
__ Yes __ No	METAMUCIL (REGULOID)	stool softener, prevents constipation	by mouth	6-8 hours **PRN** every 3-4 days **PRN**
__ Yes __ No	MILK OF MAGNESIA	laxative, for severe constipation	2-4 tablespoons by mouth with 1/2-1 full bottle with 8 oz. of water by mouth	**Do Not give if abdominal** every 3-4 days **PRN**
__ Yes __ No	CITRATE OF MAGNESIA	laxative, for severe constipation		**Do Not give if abdominal**
__ Yes __ No	PEPTO BISMOL (PINK BISMUTH SUSP)	nausea, common diarrhea, indigestion	2 tablespoons by mouth every	every 30 minutes - 1 hour **PRN** up to 8 doses
__ Yes __ No	NEOSPORIN	minor cuts/abrasions	clean affected area well, applies directly to affected area, covered with band aid if needed	2-4 times a day for no longer than 3 days

Other: _____

MD Signature: _____

If you do not want us to administer medication, we need to atleast be able to administer first aid items. Thank You