



## PRN Medication List

Participant: \_\_\_\_\_

<b>Medication</b>	<b>Reason To Give</b>	<b>Check if Approved</b>
<b>Tylenol/Acetaminophen</b>	Headache, pain, Fever	
<b>Aleve/Ibuprofen</b>	Headache, body aches, pain	
<b>Claritin/Zyrtec/Benadryl/Antihistamine</b>	Allergy, sinus	
<b>Mucinex D</b>	Chest Congestion	
<b>Cough Drops</b>	Cough	
<b>Dimetapp</b>	Cough	
<b>Dayquil/Nyquil</b>	Cold/Flu symptoms	
<b>Pepto Bismol</b>	Upset stomach, diarrhea	
<b>Milk of Magnesia</b>	Constipation	
<b>Kaopectate</b>	Diarrhea	
<b>Preparation H</b>	Hemorrhoids	
<b>Debrox ear drops</b>	Ear Wax build up	
<b>Gold Bond/Medicated Power</b>	Chafing	
<b>Dandruff Shampoo</b>	Dandruff	
<b>Neosporin/Bacitracin/Triple Antibiotic Ointment</b>	Minor cuts, abrasions,	
<b>Hydrogen Peroxide</b>	Cuts, infections	
<b>Hydrocortisone cream</b>	Itchiness, rash	
<b>Vick's VapoRub/Mentholated Topical Ointment</b>	Congestion, cough	
<b>Icy Hot</b>	Muscle soreness	
<b>Orajel</b>	Denture and canker sores	
<b>Boost/Ensure/Nutritional Drink</b>	Weight maintenance	
<b>Other:</b>		
<b>Other:</b>		
<b>Other:</b>		
<b>Other:</b>		
<b>Other:</b>		

Primary Care Provider Approval: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Guardian Approval: \_\_\_\_\_ Date: \_\_\_\_\_