

# NAVAL HEALTH CLINIC ANNAPOLIS OVER THE COUNTER (OTC) MEDICATION REQUEST FORM

(THIS FORM IS SUBJECT TO PRIVACY ACT OF 1974)

Attention Beneficiaries: Our OTC program is guided by the Manual of the Medical Department, chapter 21, which explicitly states that patients are not authorized to select their own medication. The patients or their representatives are required to present their symptoms to a non-physician health screener, who will then enter the recommended medication into the patient's profile before dispensing the drug, if deemed appropriate. The screener may also use their clinical judgement to refer patients for more definitive care. Current symptoms must be present and the condition must be considered minor. The quantity of the medication given will be limited to only a few days or enough for one treatment regimen.

## 1. The following information is required:

PATIENT'S NAME: \_\_\_\_\_ PATIENT'S DOB: \_\_\_\_\_

PATIENT'S DoD ID NUMBER: \_\_\_\_\_

SPONSOR'S NAME: \_\_\_\_\_ SPONSOR'S DoDID #: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

MEDICATION ALLERGIES \_\_\_\_\_

## 2. By signing below, I (the patient or patient's representative) certify the following:

### A. The patient **CURRENTLY** has the following symptoms:

- |   |                                   |                                      |
|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Pain             | <input type="checkbox"/> Fever    | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Itching  | <input type="checkbox"/> Rash        |
| <input type="checkbox"/> Cough            | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies   |
| <input type="checkbox"/> Other: _____     |                                   |                                      |

B. The patient does not wish to see a health provider for advice before receiving the medication. The patient understands that the medication is to be used for **acute minor illnesses or conditions**, and that if symptoms worsen or do not improve within **48 hours**, the patient should be seen by a medical provider.

### C. The patient is **NOT**:

- A) **On flying status** or an aviation service selectee candidate, or  
B) **Pregnant or breastfeeding.**

D. For patients **less than 12** years of age, contact the patient's provider for assistance with dosing.

E. The patient understands that there is a limit of **no more than 1** of each item, and **no more than 5** items per family per month.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT'S DoD ID #: \_\_\_\_\_ DATE: \_\_\_\_\_

PAIN/FEVER	
	Tylenol 325mg tablets, #50
	Ibuprofen 200mg tablets, #24
	Tylenol Elixir 160mg/5ml, 120ml
	Ibuprofen Liquid 100mg/5ml, 120ml
COUGH/THROAT	
	Robitussin Expectorant, 120ml
	Robitussin DM Cough Suppressant, 120ml
	Mucinex 600mg tablets, #20
	Chloraseptic Lozenges, #18
ITCHING ALLERGIES/RASH	
	Benadryl Liquid, 120ml**
	Benadryl 25mg tablets, #24**
	Zyrtec 10mg tablets, #30
	Zyrtec Liquid, 120ml
GI DISCOMFORT	
	Pepto-Bismol Liquid, 240ml
	Pepto-Bismol tablets, #30
	Imodium tablets, #12
DECONGESTANT	
	Afrin Nasal Spray, #1*
	Sodium Chloride Nasal Spray, #1
DRY EYES	
	Artificial Tears, #1
RASH	
	Hydrocortisone 1% Cream, #1
	Clotrimazole 1% Cream, #1
	Bacitracin Ointment, #1
	Zinc Oxide 20% Ointment, #1 (diaper rash)
WELL-WOMAN	
	Miconazole 2% Vaginal Cream, #1
EMERGENCY CONTRACEPTIVE	
	Plan B (Pharmacist ONLY)

\*Medicated decongestants are not recommended for patients with high blood pressure

\*\*Can cause drowsiness, caution with machinery

\_\_\_ Symptoms above were reviewed.

\_\_\_ The patient has been informed to see his/her provider in regards to treating his/her conditions with over the counter medications dispensed.

\_\_\_ Checked medications have been dispensed with no medical advice given.

\_\_\_ The patient is not allergic to the medications dispensed.

\_\_\_ Plan B is only dispensed by the pharmacist.

Signature of Screener: \_\_\_\_\_

Date \_\_\_\_\_