Parent/Guardian Authorization for the Administration of Non-Prescription Topical Medications by Child Care Personnel

To Child Care Personnel:

I hereby request that the following non-prescription topical medications be administered to my child by a child care staff member of the ______.

(Name of child day care program)

I understand that I must supply the child care program with the non-prescription topical medication in the original container labeled with the child's name, name of the medication, and the directions of the medication administration.

This authorization is limited to the following t	opical medications:			
1. Diaper changing or other ointments free of a	1	ions		
2. Medicated powders				
3. Teething, gum, or lip medications				
Name of Child:	Date of Birth:			
Address:		_		
Name of Medication:		_		
Schedule of Administration:				
Site of Administration:				
Reason medication is being administered:				
Medication shall be administered from:	to:	_		
Name of Parent/Guardian	Date:			
I have administered at least one dose of the	above medication to my child without a	adverse side effects.		
Signature:	Relationship to child:			
Address:	Telephone:			
Staff to complete:				
Parent authorization form and medication rece	vived by:	_		
	(Signature of staff)			
Medication Started:				
Medication Ended:	(date and time)			
Parent permission and medication administration record	I shall become part of the child's health record when the	e medication has ended.		

Medication Administration Record (MAR)

Name of Child	_ Date of Birth///
Pharmacy Name	_ Prescription Number
Medication Order	

Date	Time	Dosage	Remarks	Was This Medication Self Administered?		Signature of Person Observing or Administering Medication
				Yes	No No	
				Yes	🗌 No	
				Yes	No No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes		
				Yes		
				Yes	No	
				Yes	No	
				Yes		
				Yes		
				Yes	No	
				Yes	No	
*Medicatio	on authoriza	ation form n	nust be used as either a			ed first and second page.
		rm is compl				iately labeled
Medication is in original container		Date on label is current				

te on label is	current
----------------	---------

Person Accepting Medication (print name)_____ Date ____/___