

NON-INGESTIBLE OVER THE COUNTER MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name _____ Date of Birth ____ / ____ / ____

Program Name _____

**I give permission for the administration of the following non-ingestible over the counter medications
(mark all that apply):**

Diaper Rash Cream/Ointments _____

Insect Repellent _____

Sunscreen _____

Cortisone/Anti-Itch Creams/Ointments _____

Medicated Lip Treatments _____

OTC Antibiotic Creams/Ointments _____

Burn Creams/Sprays _____

Other Non-Ingestible OTC's: (Please Specify) _____

To administer a non-ingestible over the counter medication:

- The medication must be brought to the day care facility from the parent;
- The medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions _____ Refrigeration? _____

Parent/Guardian Signature (required) _____ Date: ____ / ____ / ____

*** This document must be updated on an annual basis.**

Unused Medication: (check one) Returned to Parent Y N Discarded appropriately Y N

By: _____

Date: ____ / ____ / ____

***Keep in the child's file when medication is finished.**