



PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF  
NON-PRESCRIPTION TOPICAL MEDICATIONS BY DAY CARE PERSONNEL

To child care program's nurse, director or teacher:

I hereby request that the following non-prescription TOPICAL medication be administered to my child by a staff member of the Edith B. Jackson Child Care Program, Inc. with the non-prescription TOPICAL medication IN THE ORIGINAL CONTAINER, LABELED WITH MY CHILD'S NAME, the name of the medication and the directions for the medication administration

This authorization is limited to the following topical medications

- Non-prescription diaper changing or other ointments that are free of antibiotic, antifungal or steroidal components
- Non-prescription medicated powders
- Non-prescription teething, gum, or lip medications

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Reason medication is being administered \_\_\_\_\_

Medication name \_\_\_\_\_

Dosage and Method of administration \_\_\_\_\_

Area of application \_\_\_\_\_

Schedule of administration \_\_\_\_\_

Start date \_\_\_\_\_ Ending date \_\_\_\_\_

- I have administered at least one dose of the above medication to my child without adverse side effects

Name of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Parent Authorization form and medication received by \_\_\_\_\_

Medication started \_\_\_\_\_ Signature of Staff  
(Date and Time)

Parent Authorization Form and Medication reviewed by  
Director \_\_\_\_\_ Date \_\_\_\_\_ Nurse Consultant \_\_\_\_\_ Date \_\_\_\_\_

