Parent/Guardian Authorization for the Administration of Non-Prescription Medication as Described Below

The authorization is limited to the following topical medications:

1. Non-prescription diaper changing ointment that are free of antibiotics, antifungal, or steroidal components
2. Non-prescription medicated powders
3. Non-prescription teething medications
4. Non-prescription insect repellents
5. Non-prescription sunscreen protectant

1. Name of Child: ____ Date of Birth: __________

Address: ____

2. Medication: ____

3. Dose/Amount: ____

4. Route/area of application: ____

5. Time/symptoms to give medication: ____

Medication shall be administered from ____________________ to _______________________
Date Date

Reason for which medication is being administered: ___________________________________

I hereby request that the above directions are follower in administering the non-prescription topical medication to my child, ____________________________________, by a staff member of the child care facility. I understand that I must supply the child's name, the name of the medication, and the directions for the medication administration. I have administered at least one dose of the above medication to my child without adverse side effects.

Name of Parent/Guardian (print): ________________________________ Date: _____________

Signature: ______________________________________ Relationship to Child: ____________

Address: ____

Daytime Phone Number: ____

For Staff to Complete:

Parent Authorization Form and medication received by: ________________________________
Signature of Staff

Medication started (date and time): __________________________

Medication ended (date and time): ___________________________

Medication Administration Record (MAR)

Name of Child/Student ______________________ **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	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is in original container**

☐ **Medication is appropriately labeled**

☐ **Date on label is current**

Person Accepting Medication (print name) ______________________ **Date** ____/____/____