



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 followed 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
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

- | | |
|--|--|
| <input type="checkbox"/> Authorization form is complete | <input type="checkbox"/> Medication is appropriately labeled |
| <input type="checkbox"/> Medication is in original container | <input type="checkbox"/> Date on label is current |

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