

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 topical medications:

1. Diaper changing or other ointments free of antibiotic, antifungal or steroidal medications
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 adverse side effects.**

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

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Staff to complete:

Parent authorization form and medication received by: \_\_\_\_\_

(Signature of staff)

Medication Started: \_\_\_\_\_ (date and time)

Medication Ended: \_\_\_\_\_ (date and time)

Parent permission and medication administration record shall become part of the child's health record when the 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
				<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	
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				<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 \_\_\_\_/\_\_\_\_/\_\_\_\_