

NON-INGESTIBLE OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

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

I give permission for the administration of 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 (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC 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 Y/N

Parent/Guardian Signature (required) _____

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

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date ____/____/____

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