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 Cornerstone Children's Center.

I understand that I must supply Cornerstone Children's Center 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	Medication Self Administered?	Signature of Person Administering Medication
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	
				No	

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

☐ **Medication Expiration Date** _____

☐ **Authorization form is complete**
☐ **Medication is in original container**
☐ **Medication is appropriately labeled**
☐ **Date on label is current**

Person Accepting/Checking medication_____ _____/_____/_____
(Print name) **Date**