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 Strong Start Early Care & Education.
(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
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
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				☐ 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** _____/_____/_____