PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATIONS BY DAY CARE PERSONNEL

I hereby request that the following non-prescription topical medication be administered to my child by a staff member of Scotty's Kiddy Korner Preschool and Day Care, LLC. I understand that I must supply Scotty's Kiddy Korner Preschool and Day Care, LLC with the non-prescription topical medication in the original container labeled with my child's name, the name of the medication and the directions for the non-prescription topical medication's administration.

This authorization is limited to the following topical medications:

1. Non-prescription diaper changing ointments that are free of antibiotics, antifungal or steroidal components
2. Non-prescription medicated powders
3. Non-prescription teething medications
4. Non-prescription body lotions

Name of Child:	Date of Birth:
Address:	
Medication Name: Method of Administration: Area of Application:	

Schedule of Administration:

Medication shall be administered from	Start Date:	End Date:
Reason for which Medication is being administered:		

☐ I have administered at least one dose of the above medication to my child without adverse side effects

Name of Parent/Guardian:		Date:
Signature:	Relationship to Child:	
Address:		Telephone:

FOR STAFF TO COMPLETE:
Parent/Guardian Authorization Form and Medication received by:
Medication Started (date & time):
Medication ended (date & time):

When the application of the above Non-Prescription Topical Medication is no longer required (when end date is reached), this form and all of its additional continuation pages shall be completed with the recording of the date treatment ended and shall be placed in the child's file to become part of the child's medical record.

Scotty's Kiddy Korner Preschool and Day Care, LLC - 70 West Road - Ellington, CT 06029
Tel: (860)870-9852 - Fax: (860-872-6093 - Email: skkpdc@skkpdc.com

This form must be filled out by administering day care staff
for all non-prescription topical medications

Complete this form before administering the non-prescription topical medication

Name of Child	D.O.B.:	
Parent/Guardian Name:		
Name of Non-Prescription Topical Medication:		
Is Medication in the original container, labeled with the child's name and directions for administration?		Yes_____ No_____
Special Instructions:		

Date	Time		Administering Staff's Signature	Notes/Comments
	am	pm		

Complete this form before administering the non-prescription topical medication

See pages 1 and 2 for full instructions

Name of Child	D.O.B.:	
Name of Non-Prescription Topical Medication:		

Date	Time		Administering Staff's Signature	Notes/Comments
	am	pm		

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