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TOPICAL MEDICATION AUTHORIZATION

Name of Child: ____ Date: _____

All topically applied creams and salves require completion of Topical Medication Authorization. All non-prescription medication shall be in the original container and labelled by the parent(s)/guardian(s) with the child's name and instructions for administration including times and amounts for doses. Some may require authorization from child's physician. This form is valid only for the dates indicated below.

I authorize preschool personnel to administer the following topical medication to my child:

____ ____________

Parent/Guardian Date

Name of Physician: ______________________ Physician Phone: ________________________

Physician Signature (if requested): __________________________ Date: _______

Type of Topical Medication: ☐ **sunblock** ☐ **lotion** ☐ **insect repellent** ☐ **lip balm**			
Name of Medication		**Dosage**	**Mode of Application**
Active Ingredients	**Expiration Date**	**Begin Date**	**Stop Date**

Type of Topical Medication: ☐ **sunblock** ☐ **lotion** ☐ **insect repellent** ☐ **lip balm**			
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