## Preschool 2019/2020

## Non-Prescription Topical Medication



I hereby request that the following non-prescription topical medications be administered to my child by a child care staff member of the **Earthplace Preschool 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:	DOB:					
Address:						
Medication (brand name):						
Site of Administration (exposed skin, diaper area, etc):						
Reason medication is being administered:						
Medication shall be administered from:	То:					
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 & time):						
Medication ended (date & time):						

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## Medication Administration Record



Name of Child:						DOB:	
Pharmacy Name:					Prescription #:		
Medicatio	on Order						
Medicatio	, i	1	1			1	
Date	Time	Dosage	Remarks	Was this self admi	medication nistered?	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		
				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 appropriately labeled					
Medication is in original container			Date on label is current				
Person accepting medication (print name):					Date:		