TOPICAL CREAM/OINTMENT FORM

Child’s Name__________________________________ Date_____________________

Please indicate what topical cream/ointment (not applied to open wound/broken skin*) you will provide and give us permission to use for your child’s care:

Name of cream/ointment:__________________________________________________

Times to be given:_________________________________________________________

Reasons for cream/ointment:_______________________________________________

Possible side effects:____________________________________________________

All creams/ointments must be in original container with original label containing the name of the child affixed.

Parents’ Signature  ___________________________________________________________________
(Both parents where applicable)  ___________________________________________________________________

*Any creams/ointments applied to open wounds/broken skin must have authorization from child’s health care provider.