NON-PRESCRIPTION TOPICAL MEDICATION FORM

Child’s Name__________________________________ Date_____________________

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

Name of medication:____________________________________________________

Times medication to be given:____________________________________________

Reasons for medication:_________________________________________________

Possible side effects:____________________________________________________

All medicines must be in original container with original label containing the name of the child affixed.

Parents’ Signature    __________________________________________
(Both parents where applicable) __________________________________________

*Any non-prescription medication applied to open wounds/broken skin must have authorization from child’s health care provider.