Abundance of Joy

Parent/Guardian Authorization for the Administration of

Non-Prescription Topical Medications by Child Care Personnel

To Child Care Personnel:

I hereby request that the following non-prescription topical medications be administered to my child by a childcare staff member of ***Abundance of Joy***

I understand that I must supply the childcare 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: _____ Date of Birth: _____
Address: _____
Name of Medication: _____
Schedule of Administration: _____
Medication applied to: _____
Reason medication is being administered: _____
Medication shall be administered from: _____ to: _____
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 and time)
Medication Ended: _____ (date and time)
Parent permission and medication administration record shall become part of the child's health record when the medication has ended.

Medication Administration Record (MAR)

Name of Child _____ **Date of Birth** _____/_____/_____
Pharmacy Name _____ **Prescription Number** _____
Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered? (Circle)	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	
				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** _____/_____/_____