Medication Authorization Form for Topical Creams

Child's Full Name_____ Class_____

Medication Name_____ Rx #_____

Time Medication is to be given: (Please circle)

12 noon 4pm At Each Diaper Change As Needed

Special Instructions: _____

Dates to be given_____ through_____
(Two week maximum)

_____ _____
Signature (Parent/Guardian) Date

For Center Use:

	Date	Time Given	Administered by		Date	Time Given	Administered by
1.	_____	_____	_____	11.	_____	_____	_____
2.	_____	_____	_____	12.	_____	_____	_____
3.	_____	_____	_____	13.	_____	_____	_____
4.	_____	_____	_____	14.	_____	_____	_____
5.	_____	_____	_____	15.	_____	_____	_____
6.	_____	_____	_____	16.	_____	_____	_____
7.	_____	_____	_____	17.	_____	_____	_____
8.	_____	_____	_____	18.	_____	_____	_____
9.	_____	_____	_____	19.	_____	_____	_____
10.	_____	_____	_____	20.	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe.

_____
_____
_____
_____