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.

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