Parent/Guardian Authorization for the Administration of Non-Prescription Topical Medications by Program Staff

To Staff:

I hereby request that the following non-prescription topical medications be administered to my child by a staff member of the SONCCA Program.

I understand that I must supply SONCCA with the non-prescription topical medication in the original container labeled with the child's name, name of medication, and the directions of the medication administration.

Name of Child:_____**Date of Birth**_____

Address:_____

Name of Medication:_____

Schedule of Administration:_____

Site of Administration:_____

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:

Parents authorization form and medication received by:_____
Signature of Staff Person

Medication Started:_____**Medication Ended:**_____
Date and Time **Date and Time**