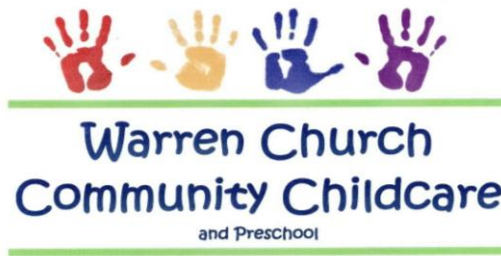


4 Sackett Hill Road  
Warren, CT 06754



Tel: (860) 868-2236

**PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATIONS BY CHILDCARE PERSONNEL**

To Childcare Personnel:

I hereby request that the following non-prescription topical medications be administered to my child by a childcare staff member of the Warren Church Community Childcare.

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
4. Insect repellents, free of DEET
5. Sunscreen that is free of amnio benzoic acid (PABA) or its derivatives.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

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 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.



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**Warren Church  
Community Childcare**  
and Preschool

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