Non-Prescription Topical Medications Authorization

Child's Name:	
Date of Birth:	
Parent/ Guardian Name:	

This authorization is limited to the following topical medications:

1. Soaps
2. Diaper Changing or other ointments FREE of antibiotic, antifungal or steroid medications
3. Lip Medications
4. Lotions

By signing below, you are acknowledging that:

- I have checked ingredient labels and I know this product is safe for my child and my child has no known allergies to this product.
- I have administered at least one dose of this medication to my child without adverse side effects.
- I am aware that these products cannot be applied to an open wound without a doctor's permission.
- I acknowledge that the uses of topical medications are for PREVENTATIVE use only. If my child has eczema or any other skin condition requiring medicated lotions, such as cortisone cream, a doctor must fill out the Medication Agreement Form.
- I permit the staff to assist my child in using the topical medication when necessary to do so.
- Topical medications will be marked with permanent ink with the child's name on the original container and must always be in the teacher's possession.
- I understand that my child may not share these items while at school. If they do so, they may no longer be able to use them.

Name of Topical Medication:_____

Site of Administration:_____

_____

When to Administer:_____

This agreement is Valid August 1st, 2025 through July 31st, 2026

Parent Signature and Date: _____