



Non - Prescription Medication Permission

Child's Name: _____

I authorize _____ to
(Provider's name)

administer the following products on an as needed or as directed basis, in accordance with the manufacturer's directions.

| | | | |
|--------------------------|--|------------------|--|
| Baby Wipes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diaper Ointments | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Baby Lotion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sunscreen | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anti-Bacterial Ointments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Insect Repellent | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Vaseline | <input type="checkbox"/> Yes <input type="checkbox"/> No | Baby Wipes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Acetaminophen | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ibuprofen | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Band-aids | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anti-Itch Cream | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Decongestant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Antihistamine | <input type="checkbox"/> Yes <input type="checkbox"/> No |

List any other **non - prescription** medications that you authorize application of:

Parent / Guardian Signature

Printed Name

Relationship

Date