OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____ Date of Birth____/___/___

Program Name_____ Today's Date____/___/___

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I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

- ☐ Diaper Rash Cream/Ointments
- ☐ Insect Repellent
- ☐ Sunscreen
- ☐ Cortisone/Anti-Itch Creams/Ointments
- ☐ Medicated Lip Treatments
- ☐ OTC Antibiotic Creams/Ointments
- ☐ Teething Tablets/Ointments
- ☐ Burn Creams/Sprays
- ☐ Other Non-Ingestible OTC's: (Please Specify)_____
  - ☐ _____
  - ☐ _____
  - ☐ _____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication.
- The child's name must be on the original container

Special handling/storage Instructions_____ Refrigeration Y/N

Parent/Guardian Signature (required)_____

* This document must be updated on an annual basis.

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date ____/____/____

*Keep in the child's file when medication is finished.

Authorization of Medical Treatment

AUTHORIZED ADULTS

In the event of an emergency, please indicate your name and phone number where you and authorized person can be reached.

Father's name _____ Phone _____

Mother's name _____ Phone _____

Another authorized person _____

Address _____

I, _____ hereby give permission to St. Anthony Preschool

To obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is _____ and date of birth is _____ should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians/dentists may be taken. I further consent to transportation of the above named child to the nearest or most appropriated medical facility.

The medical insurance company that covers the above named child is:

Company Name _____

Company Address _____

Name of Policy Holder _____ Policy Number _____

I authorize the hospital and attending physicians to submit claims to the above named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____