Over-The-Counter Topical Medication-Parent/Guardian Authorization

- In this Early Head Start/Head Start/ECEAP program, we believe that medication is best administered at home by the family. Particularly for children in our part day classrooms, we request that the schedule for administration of needed medication be adjusted, when possible, so that it is given at home.
- Sunscreen, ointments intended for the diaper area, and ointments to reduce itching or dry skin or lips can be applied when authorized in writing by parent/guardian.
- Over-the-counter medications must be in the original container and applied in a manner consistent with manufacturer's directions.
- Any over-the-counter medication must have first been tried at home before the classroom can apply.
- Parent authorization for over-the-counter medications must be renewed annually.

***Parent/Guardian**: Please Complete the Following Information*

Child Name _____

Health Concern _____

Name of Medication _____

Amount and Method of Administration _____

Time to be Applied at School _____

How Long Medication to be Continued _____

How Medication should be stored _____

Child's know medication allergies _____

If this is an AS NEEDED medication, please be specific about symptoms that prompt its administration:

I have previously applied the above named over-the-counter topical medication to my child and there was no unexpected reaction. I authorize staff to apply the same medication as directed above. I also give my permission for an exchange of information between Early Head Start and my child's health care provider regarding medication if necessary.

Parent/Guardian Signature_____Date_____

Administration/Observation Log on Back

MEDICATION ADMINISTRATION RECORD

Child Name: **DOB:**

Complete the following when medication is **received** in the classroom/center:

Date: **Signature Parent/Guardian:** **Staff Initials:**

Complete the following when medication is **discontinued/returned** to parent/guardian:

Date: **Signature Parent/Guardian:** **Staff Initials"**

Administration/Observation Log

Medication Administered	Date/Time	Dosage	Route	Name of person administering medication	Signature of person administering medication	Comments/ Observations