Permission to Administer Over-the-Counter Topical Medications

If your child must use specific brands of any of the products listed, please indicate the brand name of the product next to the category. If any brand is acceptable just check yes, or no beside the product.

_____ YES	**_____ NO**	**Insect Repellent**
_____ YES	**_____ NO**	**Sunscreen**
_____ YES	**_____ NO**	**First Aid Cream / Spray**
_____ YES	**_____ NO**	**Triple Antibiotic Cream / Ointment**
_____ YES	**_____ NO**	**Antiseptic Cream / Spray**
_____ YES	**_____ NO**	**Bee Sting Pads**
_____ YES	**_____ NO**	**Diaper Cream**
_____ YES	**_____ NO**	**Burn Cream**

I, _____ give permission to my child care provider to apply topical Over-the-Counter medications to my child,

_____ according to label directions. I understand that the stocked brand may be used unless I have indicated a specific brand above.

This permission will be in effect from <u>ENROLLMENT</u> to <u>END OF CARE</u>.

_____ _____
Parent or Guardian Printed Name **Date**

_____ _____
Parent or Guardian Signature **Date**