PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATIONS BY PUTNAM INDIAN FIELD SCHOOL STAFF

I hereby request that the following non-prescription topical medication be administered to my child by a staff member of Putnam Indian Field School. I understand that I must supply PIFS with the non-prescription topical medication in the original container labeled with my child's name, the name of the medication and the directions for the administration.

This authorization is limited to the following topical medications:

Diaper changing or other ointments free of antibiotic,
antifungal or steroidal medications
Medicated powders
Teething, gum or lip medications

Name of Child ______________________________ Date of Birth ____________

Address ____

Medication: Name, method of administration, area of application ________________

____

Schedule of administration ____

Medication shall be administered from ____________________ to ____________________
(Date) (Date)

Reason for which medication is being administered __________________________

____

I have administered at least one dose of the above medication
to my child without adverse side effects.

Name of Parent/Guardian ___________________________ Date ____________

Signature ___________________________________ Relationship to Child _______

Address ___________________________________ Phone No. __________________

FOR STAFF TO COMPLETE

Parent authorization form and medication received by __________________________
(Signature of Staff)

Medication started ________________________________ (Date and Time)

Medication ended ________________________________ (Date and Time)

Medication Administration Record (MAR)

Child Name ______________________________ Date of Birth ______________

Pharmacy Name ___________________________ Prescription Number _________

Medication Order ____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Staff Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
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				☐ Yes ☐ No	
				☐ Yes ☐ No	

☐ Authorization form is complete
☐ Medication is in original container
☐ Medication is appropriately labeled
☐ Date on label is current

Person Accepting Medication (print name) ____________________ Date ___________