



# 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:

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\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date