DPHHS-QAD/CCL-120
(Revision 11/19)

NON-INGESTIBLE OVER THE COUNTER MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____ Date of Birth ____/____/____

Program Name Billings Catholic Schools ECC

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I give permission for the administration of the 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 _____
- ☐ Burn Creams/Sprays _____
- ☐ Other Non-Ingestible OTC's: (Please Specify) _____

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To administer a non-ingestible over the counter medication:

- The medication must be brought to the day care facility from the parent;
- The 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**?** ____

Parent/Guardian Signature (required)_____ Date: ____/____/____

*** This document must be updated on an annual basis.**

Unused Medication: (check one) Returned to Parent Y☐ N☐ Discarded appropriately Y☐ N☐

By: _____ **Date:** ____/____/____

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