Medication Authorization Form

Child's Name:	**Date of Birth/Age:**
Name of Medication: diaper ointment	**Reason for Medication:** for the treatment of diaper rash
Start Date:	**Stop Date:**
Times to be given: When signs of diaper rash appear, such as: redness, irritation, sores	**Amount to be given:** enough to coat afflicted area with thin layer of ointment
Possible Side Effects:	☐ **Oral** **X Topical** ☐ **Other**
☐ **Above information consistent with label?** Yes	**Requires Refrigeration:** ☐ **yes X no**
Special Instructions:	

_____ _____

Parent/Guardian Signature **Date**

_____

Daytime Phone Number

Medication Record

(Must be filled out by the person who gives the medication)

Child's Name:
Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Signatures that correspond to initials of persons giving medication:

_____ _____

_____ _____