

# PERMISSION TO ADMINISTER

I HEREBY GIVE MY CHILD CARE PROVIDER PERMISSION TO ADMINISTER THE FOLLOWING PRODUCTS ACCORDING TO THE MANUFACTURERS' INSTRUCTIONS OR AS SPECIFIED IN WRITING BY MY CHILD'S PHYSICIAN.

**CHILD'S NAME:** \_\_\_\_\_

NO	YES	PRODUCTS	BRANDS
<input type="checkbox"/>	<input type="checkbox"/>	Acetaminophen (eg., Tylenol) _____ (following telephone permission from parent or a physician)	
<input type="checkbox"/>	<input type="checkbox"/>	Adhesive Tape _____	
<input type="checkbox"/>	<input type="checkbox"/>	Antiseptic _____	
<input type="checkbox"/>	<input type="checkbox"/>	Baby Lotion _____	
<input type="checkbox"/>	<input type="checkbox"/>	Baby Oil _____	
<input type="checkbox"/>	<input type="checkbox"/>	Baby Powder _____	
<input type="checkbox"/>	<input type="checkbox"/>	Band-Aids _____	
<input type="checkbox"/>	<input type="checkbox"/>	Bar Soap _____	
<input type="checkbox"/>	<input type="checkbox"/>	Burn/Sunburn Remedy _____	
<input type="checkbox"/>	<input type="checkbox"/>	Conditioner _____	
<input type="checkbox"/>	<input type="checkbox"/>	Diaper Ointment _____	
<input type="checkbox"/>	<input type="checkbox"/>	Diaper Wipes _____	
<input type="checkbox"/>	<input type="checkbox"/>	First Aid Cream _____	
<input type="checkbox"/>	<input type="checkbox"/>	Hydrogen Peroxide _____	
<input type="checkbox"/>	<input type="checkbox"/>	Insect Repellent _____	
<input type="checkbox"/>	<input type="checkbox"/>	Itching Cream _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lip Balm _____	

NO	YES	PRODUCTS	BRANDS
<input type="checkbox"/>	<input type="checkbox"/>	Liquid Soap _____	
<input type="checkbox"/>	<input type="checkbox"/>	Menthol Rubs _____	
<input type="checkbox"/>	<input type="checkbox"/>	Moisturizing Lotion _____	
<input type="checkbox"/>	<input type="checkbox"/>	Nail Polish _____	
<input type="checkbox"/>	<input type="checkbox"/>	Petroleum Gel _____	
<input type="checkbox"/>	<input type="checkbox"/>	Rash Ointment _____	
<input type="checkbox"/>	<input type="checkbox"/>	Shampoo _____	
<input type="checkbox"/>	<input type="checkbox"/>	Sunscreen _____	
<input type="checkbox"/>	<input type="checkbox"/>	Teething Ointment _____	
<input type="checkbox"/>	<input type="checkbox"/>	Toothpaste _____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	

SEPARATE PERMISSION FORMS ARE REQUIRED FOR ALL OVER-THE-COUNTER MEDICATIONS (eg., cough syrup, cold medication), AND FOR ALL PRESCRIPTIONS. THIS FORM MUST BE UPDATED ANNUALLY.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date