



Planting Roots Preschool
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Topical Over the Counter (OTC) Medication Authorization Form

To be completed by parent

Child's Name: _____ Date of Birth: _____

**I give permission for the administration of the following non-ingestible over the counter medications:
(Mark all that apply and note specific brand, or note if you have no brand preference.)**

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)

To administer a non-ingestible over the counter (OTC) medication:

-The OTC medication must be in its original container, and manufacturer's instructions must be followed.

Parent/Guardian Signature

Date

When an over the counter medication is used, parents must be notified that day.