



Permission to Administer Over-the-Counter Topical Medications

OVER-THE-COUNTER Medication Checklist

Please check off any over-the-counter topical medications that you will allow the CELC staff to administer to your child. If your child must use a specific brand for any of the products listed, please check yes and indicate the brand name of the product next to the category. If any brand is acceptable just check No beside the product. Specific brands must be supplied by families.

Over-The-Counter Medication Permission

I, _____ give permission to the Clinton Early Learning Center to apply topical over-the-counter medications to my child, _____, according to label directions. I understand that the stocked brand may be used unless I have indicated a specific brand above and will supply that brand for my child. I understand that I must label products that are specific to my child with his/her first and last name.

Approval	Product	Does your child need to use a specific brand?	What is that brand? <i>These items must be supplied by the parent.</i>
Parent's Initial _____	Cutter Skinsations Insect Repellent	<input type="checkbox"/> Yes <input type="checkbox"/> No	We DO NOT provide SUNSCREEN/BUGSPRAY- we do have extra in case the bottles you provide run out and we need to apply more. MUST BE PROVIDED –we stock this brand in case yours runs low. If you don't provide this, we will be happy to purchase if for you at an additional cost.
Parent's Initial _____	Thinksport Kid's Safe Sunscreen SPF 50+	<input type="checkbox"/> Yes <input type="checkbox"/> No	MUST BE PROVIDED –we stock this brand in case yours runs low. If you don't provide this, we will be happy to purchase if for you at an additional cost.
Parent's Initial _____	First Aid Cream/Spray	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent's Initial _____	Calamine Lotion	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent's Initial _____	Bandage	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent's Initial _____	Hand Sanitizer (When running water and soap is not available)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent's Initial _____	Triple Antibiotic Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No	

This permission will be in effect from September 1, 2018 to March 1, 2019.

Parent Signature _____ Date _____