

O.T.C. Topical Medication Form

Medication must be in the **original container** with the **child's name** clearly written on it.

Child's **Name**

Child's **Age**

Topical Medication Information	
I give permission for my child's day care provider to apply or help my child apply	
<input type="checkbox"/> Sunscreen <input type="checkbox"/> Moisturizer <input type="checkbox"/> Lip balm <input type="checkbox"/> Over the counter diaper cream	
Type of medication(s) provided	
Special Instructions	
Beginning date	End date

I understand that my child's teacher will promptly inform me of any skin reaction or any other reactions to these products.

Signature	
<input type="text"/>	<input type="text"/>
Authorized center signature	Date



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Office Use Only

Child's current classroom assignment	
Date information provided to teachers	Administrator initials