PERMISION TO ADMINISTER

OVER THE COUNTER MEDICATION

Child's Name :_____ Age:_____

Provider's Choice	Brand Name
Sunblock/Lotion	_____
Diaper Cream	_____
Burn/Insect Bite Spray	_____
Insect Repellent	_____
Congestion	_____
Fever	_____
Diarrhea	_____
Vomiting	_____
Upset Stomach	_____
Headache	_____

Parent's Signature:_____

Date:_____

Doctor's Signature:_____

Date:_____

Provider's Notes: