



## AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION

I hereby authorize **Children's House, Inc.** to administer the following medication(s) to my child \_\_\_\_\_. **Child's Date of Birth:** \_\_\_\_\_

**Note: The first dose of any medication new to the child must be given at home.**

**Tylenol**  
Route\*: \_\_\_\_\_  
Dosage: \_\_\_\_\_

**Motrin**  
Route\*: \_\_\_\_\_  
Dosage: \_\_\_\_\_

**Teething Medication**  
Product Name: \_\_\_\_\_  
Route\*: \_\_\_\_\_  
Dosage: \_\_\_\_\_

**Cough/Cold Medication**  
Product Name: \_\_\_\_\_  
Route\*: \_\_\_\_\_  
Dosage: \_\_\_\_\_

**Medicated Ointments/Creams**  
Product Name: \_\_\_\_\_  
Route\*: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Ok to apply to broken skin? \_\_\_\_\_

**Other**  
Product Name: \_\_\_\_\_  
Route\*: \_\_\_\_\_  
Dosage: \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_  
**Daytime Phone #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Physician's Signature (or Stamp):** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_

**Date:** \_\_\_\_\_ *This form expires one year from the date signed.*

Generic Equivalent Acceptable (Physician Initial if Acceptable)

**\*Route: Topical, Oral (pill or liquid), Injection, Nasal Spray, Inhaler, Drops, etc.**