

## Topical Skin Product Authorization Form

This form authorizes Merritt Academy to apply a non-prescription topical skin product to your child (such as Sunscreen, Diaper Ointment, Lotion, Oral Teething Medicine and Insect Repellent).

- The product must be in the original container and labeled with the child's name.
- Manufacturer's instructions for application must be followed unless authorized by child's physician.
- Aerosol cans are not permitted for sunscreen.

Child's Name:
Date of Birth:
Classroom:
Product Name:
Dosage and Times to be Given:
Any Adverse Reactions:
Special Instructions (if any):

Parent Authorization		
Merritt Academy has my permission to apply the product above.		
_____	_____	_____
<b>(Parent's Signature)</b>	<b>(Printed Name)</b>	<b>(Date)</b>
This medication is effective from: _____ and until _____ or <input type="checkbox"/> August 19, 2020 <small>(first day administered) <span style="margin-left: 150px;"></span> (last day of 2019-20 program)</small>		
<i>Authorization may not exceed the last day of the 2019-20 program.</i>		

Physician Authorization (only if instructions differ from manufacturer)		
I certify that, in my opinion, it is medically necessary that the product and dosage described above be applied to the child listed above during the hours of operation at Merritt Academy.		
_____	_____	_____
<b>(Physician's Signature)</b>	<b>(Printed Name)</b>	<b>(Date)</b>
This medication is effective from: _____ and until _____ or <input type="checkbox"/> August 19, 2020 <small>(first day administered) <span style="margin-left: 150px;"></span> (last day of 2019-20 program)</small>		
<i>Authorization may not exceed the last day of the 2019-20 program</i>		

FOR MERRITT ACADEMY OFFICE USE ONLY		
Date Received: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____