

Diaper Cream/Ointment Authorization Form

Child's Name:	Date of Birth/Age:				
Name of Medication:	Expiration Data: / /				
	Expiration Date://				
Start Date:	Stop Date: (up to 12 months after 'Start Date')				
Times to be applied:	Amount to be applied:				
□ when rash is present					
☐ with every diaper change					
☐ other: Possible side effects:					
Above information consistent with lab	pel*? □ Yes □ No				
Special Instructions:					
Reason for medication: For diaper rash Route: Topical Storage: Room temperature I authorize the use of the above diaper cre					
Parent/Guardian Signature	Date				
Health Care Provider Signature**	Date				
()					
() Health Care Provider Phone Number					

^{*} Most diaper ointment labels indicate that rashes that are not resolved, or reoccur, within 5-7 days should be evaluated by a health care provider.

^{**} Necessary only for diaper creams/ointments not labeled for use in the diaper area. (Pharmacist label on prescription medication indicates consent of health care provider.)



Diaper Cream/Ointment Application Record

(Must be filled out by the person who applies the cream/ointment)

Child's Name:

Name of Medication:											
Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials
	Ì	1					l	l			

List any **side effects** and date below. Notify parent/guardian immediately.

Signatures (& initia	ls) of p	ersons applying cream/ointment:	
 ()	()
 ()	()
 ()	()