PERMISSION TO ADMINISTER OVER-THE-COUNTER-MEDICATIONS

If Your child requires a specific brand of any of the products listed, please indicate the name of the product next to each category. If any brand is acceptable just check yes or no beside the product.

______	Yes	______	No	______________________	Sunscreen
______	Yes	______	No	______________________	First Aid Cream (Includes:Anitbiotic, Antiseptic, Disinfectant)
______	Yes	______	No	______________________	Diaper Cream (only OTC provided by parent)
______	Yes	______	No	______________________	Other (only OTC provided by parent)

I, ______________________________ give permission to
(Parent/ Guardian)

____
(MSM Staff Member)

to apply the above topical medication to

____
(Child's Name)

According to the directions on the original package.

This permission will be in effect from ______________ to ______________