



Diaper Cream/Ointment Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication:	
Start Date:	Stop Date: (up to 6 months after 'start date')
Apply topically: <input type="checkbox"/> when rash is present <input type="checkbox"/> with every diaper change <input type="checkbox"/> other:	Amount to be applied:
Possible side effects:	<input type="checkbox"/> Above information consistent with label?
Special Instructions:	

For diaper rash prevention or treatment.
Store at room temperature.

Parent/Guardian Signature

Date

Daytime Phone Number

Physician Signature*

Date

Physician Phone Number

* 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

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

Signatures (& initials) of persons applying cream/ointment:

_____	()	_____	()
_____	()	_____	()
_____	()	_____	()