

Diaper Cream/Ointment Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication:	
Expiration Date: ___/___/___	
Start Date: ___/___/___	Stop Date: (up to 12 months after 'Start Date') ___/___/___
Times to be applied: <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:	

Reason for medication: For diaper rash prevention or treatment
Route: Topical
Storage: Room temperature

I authorize the use of the above diaper cream/ointment on my child.

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.)



