Public Health
Seattle & King County

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: **when rash is present** **with every diaper change** **other:**	**Amount to be applied:**
Possible side effects:	**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:

_____ ( ) _____ ( )

_____ ( ) _____ ( )

_____ ( ) _____ ( )