

**REQUEST TO APPLY TOPICAL
MEDICATIONS
(FOR NON-PRESCRIPTION MEDICATIONS ONLY)**

Child's Name: _____ Date: _____

I request that the staff of Alphabet Academy, LLC apply the following checked topical medication to my child as needed. The authorization will be in effect until the topical medication expires or is removed from the school by the parent.

Signature: _____ Date: _____

_____ Diaper changing medication

_____ Other

Directions for Administration:

Apply As Needed

Special Directions:

