



## 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.)