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Teida’s Tots Conditional Forms

Medication and Topical-Care Authorization

Version 2026.1 · Effective August 23, 2026

Child and parent

- Child’s full name: _____
- Date of birth: _____
- Parent/guardian: _____

Product or medication

- Name: _____
- Purpose: _____
- Type: ☐ Prescription ☐ Over-the-counter ☐ Sunscreen ☐ Lotion/cream/balm ☐ Diaper ointment ☐ Other: _____
- Amount/dose: _____
- Frequency/timing: _____
- Start date: _____ End date: _____

Instructions and health-provider information

Instructions: _____

_____

- Healthcare provider: _____
- Provider phone: _____

☐ Healthcare-provider order or instructions attached, when required.

Parent authorization

I authorize Teida’s Tots to administer or apply the product identified above according to the written instructions and applicable procedures. I have disclosed known allergies, reactions, and relevant health information.

☐ My child may use only the product supplied by me.

☐ The product may be supplied by Teida’s Tots, if separately approved and identified here:
_____

Product handling

The parent must provide the product in its original container, labeled with the child's name, and within its expiration date. Teida's Tots will follow applicable storage, administration, documentation, and parent-notification procedures. Any observed reaction will be reported promptly and handled according to the emergency and health procedures.

Signatures

- Parent/guardian signature: _____
- Printed name: _____
- Date: _____

- Provider signature: _____
- Date: _____

Provider administration record

Date/time	Product/dose	Administered by	Reaction or notes	Parent notified
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No

Infant Safe-Sleep Acknowledgment

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Child

- Child's full name: _____
- Date of birth: _____

Standard sleep practices

Teida's Tots will follow applicable safe-sleep requirements and written procedures, including:

- Using an approved individual sleep space for the infant.
- Placing the infant on the back for sleep unless an applicable written health authorization or care plan permits another position.
- Keeping the sleep space free of soft bedding and other prohibited items.
- Following required supervision and physical-check procedures.

Parent information

Parent instructions or information about the infant's sleep routine:

_____

_____

☐ No additional sleep instructions at this time.

Conditional authorizations

☐ An alternate sleep-position authorization or healthcare-provider plan is attached.

☐ A swaddling authorization is attached, if applicable.

☐ No alternate sleep-position or swaddling authorization is requested.

Parent acknowledgment

I have reviewed the program's safe-sleep practices and will provide current information about my child's sleep needs. I understand that a separate written authorization or healthcare-provider plan is required for any applicable exception.

- Parent/guardian signature: _____
- Printed name: _____
- Date: _____

Annual/update review

- Last reviewed: _____
- Parent initials: _____
- Provider initials: _____

Required healthcare-provider plan attachments, when applicable

- Current healthcare-provider asthma care plan, if applicable.
- Current healthcare-provider seizure care plan, if applicable.

Parents must provide the current applicable healthcare-provider or Department-approved plan. This packet does not replace those plans.