



SOUTHERN OREGON CHILD & FAMILY COUNCIL, INC.

SOUTHERN OREGON HEAD START

HEALTH SERVICES OFFICE

1001 Beall Lane ~ P.O. Box 3697 ~ Central Point, OR 97502 ~ (541) 734-5150 ~ Fax (541) 734-5229

Please allow my child: _____ DOB: _____

to have the following over the counter product at school for personal use. I understand that I will need to provide it for my child and it will remain at school:

Item	Brand:
Hand Soap <i>(to use each time child washes their hands)</i>	
Chapstick <i>(to use as needed for dry lips)</i>	
Sunscreen <i>(to be applied prior to outside time)</i>	
Lotion <i>(as needed for dry skin)</i>	
Toothpaste <i>(to use 1 time daily after a meal)</i>	
Wipes <i>(to be used at diaper change)</i>	
Diaper Cream <i>(to be used as needed at diaper change)</i>	

Comments:

Parent/Guardian Signature _____ Date _____