

Ohio Department of Job and Family Services
**REQUEST FOR ADMINISTRATION OF MEDICATION
 FOR CHILD CARE**

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|---|---|----------------------------------|
| Box 1 | The following section must always be completed by the parent/guardian. | |
| Check all that apply and complete all of the information. | | |
| <input type="checkbox"/> Prescription Medication <input type="checkbox"/> Nonprescription Medication <input type="checkbox"/> Food Supplement <input type="checkbox"/> Topical Product or Lotion <input type="checkbox"/> Refrigeration Required <input type="checkbox"/> Modified Diet | | |
| Name of Child | Date of Birth | Weight |
| Name of Medication | | Exact Dosage |
| To be administered at the following times | | For the following period of time |
| <input type="checkbox"/> I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies). | | |
| Signature of Parent/Guardian | | Date |
| Box 2 | The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant. | |
| 1. The medication contains codeine or aspirin. 2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions). 3. It is a sample medication without a prescription label. 4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period. 5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use. | | |
| Name of child | Name of medication, vitamin, diet, supplement | |
| Dosage | Possible side effects to watch for are | |
| Expiration date (May not exceed twelve months from the date of this request for medications of food supplements). | | |
| Instructions | | |
| This child is under my care and should receive the above medication as written. Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant | | |
| Date of signature | | Phone number |
| Name of child | Name of medication, vitamin, diet, supplement | |

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

