

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

<p>This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.          It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).</p>		
Child's Name	Date of Birth <i>(if needed to determine the correct dosage)</i>	Weight <i>(if needed to determine the correct dosage)</i>
<b>Box 1</b> The following section must always be completed by the parent/guardian.		
Name of medication		Dosage
To be administered at the following times		<input type="checkbox"/> See attached For the following period of time
		Medication expiration date
<p><i>I understand:</i></p> <ol style="list-style-type: none"> <li>1. <i>This form expires twelve months from the date of my signature, if box 2 has not been completed.</i></li> <li>2. <i>That my child must receive at least one dose of medication at home prior to the program administering the medication (unless the medication is used for emergencies).</i></li> </ol>		
Signature of Parent/Guardian		Date
<b>Box 2</b> The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant when any of the following apply:		
<ol style="list-style-type: none"> <li>1. The nonprescription medication contains codeine or aspirin;</li> <li>2. A physician's instruction is needed for a nonprescription medication;</li> <li>3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;</li> <li>4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period;</li> <li>5. The intended use differs from the manufacturer's instructions or use</li> </ol>		

Instructions

See Attached

Possible side effects to watch for are

See Attached

*The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.*

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant

Date of Signature

Phone Number

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It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication
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<b>Date</b>	<b>Time</b>	<b>Dosage</b>	<b>Signature of designated person administering medication</b>