Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.					
Check all that apply and complete all of the information.						
☐ Prescription Medication ☐ Nonprescription			Medication		Supplement	
☐ Topical Product or Lotion ☐ Refrigeration Required ☐ 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			
☐ 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.					
 The medication contains codeine or aspirin. 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). It is a sample medication without a prescription label. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period. 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	Phone number			
Name of child		Name	Name of medication, vitamin, diet, supplement			

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.						
Date		Time	Dosage	Signature of Designated Person Administering Medication			