Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This for in care.	This form is to be completed for each prescription or non-prescription medication that a child needs to receive while						
It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).							
Child's Name		Date of Birth (if needed to determine the correct dosage)		Weight (if needed to determine the correct dosage)			
Box 1	Box 1 The following section must always be completed by the parent/guardian.						
Name of	medication	•	Dosage				
To be ad	ministered at the following times	· · · · · · · · · · · · · · · · · · ·	See attached For the following Medication expiration				
			period of tim	e	date		
l underst		and the second second	:51 01				
 This form expires twelve months from the date of my signature, if box 2 has not been completed. 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). 							
Signature	e 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 when any of the following apply:						
 The nonprescription medication contains codeine or aspirin; A physician's instruction is needed for a nonprescription medication; The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication; The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period; The intended use differs from the manufacturer's instructions or use 							

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Possible side effects to watch for are					
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The child is under my care and should receive the above medication as written. Line	deretand this form avaima				
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.	ŀ				
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Signature of licensed physician, licensed dentist, advanced practice registered nurse or	Date of Signature				
certified physician's assistant					
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Phone Number					

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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).

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 Medicat	Name of Medication		
Date	Time	Dosage	Signature of designated person administering medication		

Child's Name