Ohio Department of Job and Family Services

# REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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).

| Child's Name | Date of Birth *(if needed to determine the correct dosage)* | Weight *(if needed to determine the correct dosage)* |
|---|---|---|
| | | |

**Box 1** The following section must always be completed by the parent/guardian.

| Name of medication | Dosage | |
|---|---|---|
| | ☐ See attached | |
| To be administered at the following times | For the following period of time | Medication expiration date |
| | | |

*I understand:*

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *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 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:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period;
5. The intended use differs from the manufacturer's instructions or use

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

This form shall 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).

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 |
|---|---|
| | |

| Date | Time | Dosage | Signature of designated person administering medication |
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