

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 <i>(if needed to determine the correct dosage)</i>	Weight <i>(if needed to determine the correct dosage)</i>
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>I understand:</i> 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

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Child's Name	Name of Medication

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