

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.
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Check all that apply and complete all of the information.

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|---|--|--|
| <input type="checkbox"/> Prescription Medication | <input checked="" type="checkbox"/> Nonprescription Medication | <input type="checkbox"/> Food Supplement |
| <input checked="" type="checkbox"/> Topical Product or Lotion | <input type="checkbox"/> Refrigeration Required | <input type="checkbox"/> Modified Diet |

Name of Child	Date of Birth	Weight
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Name of Medication DIAPER CREAM NAME:	Exact Dosage LIBERALLY TO EXPOSED AREA
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To be administered at the following times REDNESS OR RASH OR BY PARENT REQUEST	For the following period of time 1 YEAR FROM DATE
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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
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Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.
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1. The medication contains codeine or aspirin.
2. 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).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. 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
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Dosage	Possible side effects to watch for are
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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 number
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Name of child	Name of medication, vitamin, diet, supplement
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This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.