

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

Name of medication <b>SUNSCREEN NAME:</b>	Dosage LIBERALLY TO EXPOSED AREA  <input type="checkbox"/> See attached
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To be administered at the following times <b>ANY AND ALL OUTDOOR PLAY</b>	For the following period of time <b>1 YEAR FROM DATE OF SIGNATURE</b>	Medication expiration date
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*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
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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 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