

Ohio Department of Job and Family Services
REQUEST FOR ADMINISTRATION OF MEDICATION
Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

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

<u>Check all that apply:</u>	
<input type="checkbox"/> Prescription medication	<input type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
<u>Complete all of the following information:</u>	
Name of child: _____ Date of birth: _____ Weight _____	
Name of medication: _____ Exact dosage: _____	
To be administered at the following times: _____	
For the following period of time: _____	
Parent/Guardian signature: _____	Date: _____

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive (name of child) (name of medication, vitamin, diet)		
as follows: (include dosage and instructions)		
Possible side effects to watch for are: _____		
Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)		
_____ Signature of physician, dentist or advance practice nurse	_____ Date of signature	_____ Phone number

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Box 3 - The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on the reverse side of this form.

_____ was given _____ in the amount of _____
 (Name of Child) (Name of Medication, (Dosage)
 Vitamin or Diet)

Date and Time of Dosage	Dosage Amount	Signature of Designated Person Administering Medication