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.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

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 applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; 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 OAC rules 5101:2-12-31 and 5101:2-13-31

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 page 2 of this form.

_____ was given _____ in the amount of _____

(Name of Child) (Name of Medication, Vitamin or Diet) (Dosage)

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

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