

Ohio Department of Job and Family Services  
**REQUEST FOR ADMINISTRATION OF MEDICATION  
 FOR CHILD CARE**

<b>Box 1</b>	The following section must always be completed by the parent/guardian.	
Check all that apply and complete all of the information.		
<input checked="" type="checkbox"/> Prescription Medication <input type="checkbox"/> Nonprescription Medication <input type="checkbox"/> Food Supplement <input type="checkbox"/> Topical Product or Lotion <input type="checkbox"/> Refrigeration Required <input type="checkbox"/> Modified Diet		
Name of Child		Date of Birth
Name of Medication Epi Pen, Jr.		Exact Dosage 1 injector
To be administered at the following times After child ingests _____ and child shows signs of respiratory distress, hives, swelling in face/throat/lips, or vomits more than 1 time. Call 911 and parents.		For the following period of time August 9th, 2021 through August 5th, 2022
<input type="checkbox"/> 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
<b>Box 2</b>	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.	
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
Dosage		Possible side effects to watch for are
Expiration date (May not exceed twelve months from the date of this request for medications or 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
Name of child		Name of medication, vitamin, diet, supplement

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.

**Box 3** The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

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.