Ohio Department of Job and Family Services

**REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE**

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| Box 1 | The following section must always be completed by the parent/guardian. | | | | |
| Check all that apply and complete all of the information.  Prescription Medication Nonprescription Medication Food Supplement Topical Product or Lotion Refrigeration Required Modified Diet | | | | | |
| Name of Child | | | Date of Birth | | Weight |
| Name of Medication  **HAND SANITIZER** | | | | Exact Dosage | |
| To be administered at the following times | | | For the following period of time | | |
| 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 |
| Box 2 | 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 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 | | |
| Name of child | | Name of medication, vitamin, diet, supplement | | | |

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| 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 |
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