

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR

CHILD CARE

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| 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 *(if needed to determine the correct dosage)* | Weight *(if needed to determine the correct dosage)* |
| **Box 1** | The following section must always be completed by the parent/guardian. |
| Name of medication**Hand Sanitizer** | DosageDime Size | Drop |  |  |
| See attached |  |  |
| To be administered at the following timesAs Needed | For the following period of time | Medication expiration date |
| *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).*
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| 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 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 diff ers f rom the manuf acturer's instructions or use
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