

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:**

- |   |  |
|---|--|
| <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             |

**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

