

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.

<b><u>Check all that apply:</u></b>	
<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
<b><u>Complete all of the following information:</u></b>	
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 _____		
<small>(name of child)</small>		<small>(name of medication, vitamin, diet)</small>
as follows: _____		
<small>(include dosage and instructions)</small>		
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

