

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.

| | |
|--|---|
| <u>Check all that apply:</u> | |
| <input type="checkbox"/> Prescription medication <input type="checkbox"/> Nonprescription medication <input type="checkbox"/> Refrigeration required | <input checked="" type="checkbox"/> Topical product or lotion <input type="checkbox"/> Food supplement <input type="checkbox"/> Modified diet |
| <p><i>insect repellent</i></p> | |
| <u>Complete all of the following information:</u> | |
| Name of child: _____ Date of birth: _____ Weight: _____ | |
| Name of medication: <i>insect repellent</i> Exact dosage: _____ | |
| To be administered at the following times _____ | |
| For the following period of time: <i>6/1/11 - 6/1/12</i> _____ | |
| 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

