

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 checked="" type="checkbox"/> Topical product or lotion |
| <input checked="" 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: Hand Sanitizer Exact dosage: 1-2 squirts administered by teacher or assistant

To be administered at the following times: When soap/water not available and hands need sanitized

For the following period of time: September 1, 2012 thru May 31, 2013

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 given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); 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 rules 5101:2-12-31 and 51-1:2-13-31.

