

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This fo in care.	rm is to be completed for each prescription	n or non-prescription r	medication th	at a child	needs to receive while	
It is not (JFS 0°	t required to be completed for topical prod 1236).	lucts, lotions, or if the	medication is	required l	oy a health care plan	
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 co	ompleted by the paren	t/guardian.	<u> </u>		
Name o	f medication		Dosage			
					X.	
				☐ See attached		
To be ac	dministered at the following times		For the follo period of tim		Medication expiration date	
I unders 1. 2.	stand: This form expires twelve months from the That my child must receive at least one d medication (unless the medication is used	lose of medication at h	, if box 2 has nome prior to	not been the progra	completed. am administering the	
Signatur	e 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:					
 A physical and the control of the cont	nonprescription medication contains code ysician's instruction is needed for a nonpre child does not meet the minimum age or wo prescription medication; nonprescription medication is to be given I intended use differs from the manufacture	escription medication; veight requirements as longer than three cons	s listed on the secutive days			

Instructions		
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☐ See Attached		
Possible side effects to watch for are		
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☐ See Attached		The state of the s
The child is under my care and sh	ould receive the above medication as written. I	understand this form evniros
twelve months from the date of m	/ signature	understand this form expires
The second secon		The letterated the colorest letterated
2		
Signature of licensed physician licen	sed dentist, advanced practice registered nurse or	
certified physician's assistant	and a diffusi, advanced practice registered nurse or	Date of Signature
, January Constant		
Phone Number		
		1

This form shall 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).

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name of Medication				
Time	Dosage	Signature of designated persor administering medication		
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2	8			
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		Time Dosage		