OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

Parent/Guardian Request for Administration of Medication

Box 1 must ALWAYS be completed by the parent/guardian

Box 1: **Parent/Guardian Instructions** - use one form per medication

(Check all that apply)

__ Prescription Medication
__ Nonprescription Medication
__ Refrigeration required
__ Topical Product or Lotion
__ Food Supplement
__ 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 Signature: _____ Date: _____

Request for Administration of Medication Form valid for no longer than 12 months

Box 2 is required when:

- You need physician instructions for the nonprescription medication (e.g. child is underage or underweight per the label instructions)
- It is a sample medication without a prescription label
- The nonprescription medication is to be given longer than three days or a topical product or lotion is being used to cure a skin ailment and is applied longer than 14 days
- The child is on a modified diet (an entire food group is eliminated)
- Medication contains codeine or aspirin

Box 2: To be completed by licensed physician, licensed dentist, or advance practice nurse certified to prescribe medications :

(Name of child) _____ is under my care and should receive (name of medication, vitamin, or modified diet _____ (dosage) _____ as follows _____.
Specific instructions for administration: _____
Possible side effects to watch for: _____
Expiration date (may not exceed **12 months** from date of this request if prescribing medication or food supplement): _____
Signature of Physician _____ Date of Signature _____ Phone # _____

Box 3 is for Center use only, and is to be completed by a designated person:
(Name of child) _____ was given (name of medication, vitamin, or modified diet) _____ dosage _____, at the following time(s) on the following date(s): (see below)

Date of Dosage	Amount and Time of Dosage	Signature of Designated Person Administering Medication

Use reverse side to record additional dosages, if needed

Prepared by the Ohio Department of Job and Family Services in cooperation with the Ohio Department of Health.

Note: This is a prescribed form which must be used by centers (Rule 5101:2-12-31) and type A homes (5101:2-13-31) to meet the requirement.

Date of Dosage	Amount and Time of Dosage	Signature of Designated Person Administering Medication