Reset Form

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

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

☐

Signature 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.**

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician’s instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

OTC (OVER-THE-COUNTER) MEDICATION PERMISSION FORM 2020-2021

STUDENT NAME: _____ GRADE: _____

Please indicate which medications you give written consent to be administered to your student by St. Cecilia Staff Members.

___ **I approve ALL medications listed below**

____ **I approve only the below checked medications**
____ **Tylenol/acetaminophen (liquid or caplets)**
____ **Motrin/Advil/ibuprofen (liquid or caplets)**
____ **Neosporin/Polysporin/antibiotic topical cream**
____ **Bactine First Aid antiseptic Spray**
____ **Benadryl/Cortisone/hydrocortisone anti-itch cream**
____ **Cough drops**
____ **Sunscreen**

All over-the-counter medications will be given according to the manufacturer's recommended dosage, based on your child's age. You will be notified by a message in SchoolSpeak or a note sent home with your child if a medication was administered during the school day.

___ **I DO NOT GIVE APPROVAL FOR OTC medications given to my student**

_____ _____
(Signature of Parent or Guardian) **(Date)**

_____ _____
(Signature of Physician) **(Date)**

NOTE: OTC Medications will not be administered without a valid physician signature.