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.

- [x] 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

- [ ] I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

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.

JFS 01217 (Rev. 12/2016)

Box 3 The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

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.

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YOUR PRESCRIPTION FOR SAFELY ADMINISTERING PRESCRIPTION MEDICATION

After the JFS 01217 is complete, the parent/guardian who completed the form and the staff member receiving the form should use the check boxes below to verify the medication can safely be administered.

Parent	Staff	
☐	☐	Original prescription label is attached.
☐	☐	Date on the prescription label is within the last 12 months.
☐	☐	A licensed physician, licensed dentist, or an advance practice nurse has completed Box 2 of the JFS 01217 for sample medication that does not have a prescription label attached.
☐	☐	Every item in Box 1 of the JFS 01217 has been filled in.
☐	☐	The instructions on the label exactly match the information in Box 1 of the JFS 01217 for the dosage amount and time for medication to be given.
☐	☐	If the medication is needed for a health condition such as asthma, allergies, seizure disorders, breathing problems, etc., a health care plan has been completed.
☐	☐	At least one dose already administered to child at home