



**DOD IN-HOME CHILD CARE FEE ASSISTANCE  
MEDICATION STATEMENT**

**\*\*\*This form is used by parents to decline medication administration during in-home child care\*\*\***

**Name of Sponsor:**

**Name of person completing form:**

**Relationship to Sponsor**

*(e.g., spouse or legal guardian):*

By signing this form, I hereby acknowledge that I do not wish for my qualifying child(ren) listed below to be administered medication by my in-home child care provider during in-home child care.

I further acknowledge that if these circumstances change, I understand that I must complete an *Authorization to Administer Medication* form prior to my provider administering medications.

**Name of Child**

1)

2)

3)

4)

5)

6)

**Signature:**

**Relationship to child(ren) listed above:**

**Date:**