## Maryland State Department of Education Office of Child Care Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. This authorization is NOT TO EXCEED 1 YEAR.

This form is required for both prescription and non-prescription/over-the-counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber.

Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's Picture Here (optional)

	PR	ESCRIBER'S AUTHORIZA	TION		
Child's Name:				_Date of Bi	irth:/
Medication and Strength	Dosage	Route/Method	Time & Fr	equency	Reason for Medication
Medications shall be admini	stered from: /	/to/			
If PRN, for what symptoms,					
Possible side effects and spe					
Known Food or Drug Allergie	es: □ Yes □No If y	es, please explain:			
For School Age children only			Yes □No		
,		administer this medicati		No	
PRESCRIBER'S NAME/TITLE	, , , , , , , , , , , , , , , , , , , ,				ere (Optional)
					το (ο μονονιαί)
TELEPHONE	FAX				
ADDRESS	-				
PRESCRIBER'S SIGNATURE (Pare				mp only) D	ATE (mm/dd/yyyy)
	PAREI	NT/GUARDIAN AUTHORIZA	ATION		
I authorize the child care staff					
attest that I have administere					
authority to consent to medic understand that at the end of					
discarded. I authorize child ca					
HIPAA. I understand that per					
authorization to self-carry/sel					
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)			
			MEDICATION		
CELL PHONE #		HOME PHONE #	wo	RK PHONE #	#
HEAD TO THE TENTER OF THE	atule to the route	CHILD CARE STAFF USE ON	LY		
Child Care Responsibilities:	1. Medication named	above was received. Expira	ition date		☐ Yes ☐ No
	2. Medication labeled	as required by COMAR.			] Yes □ No
	3. OCC 1214 Emergen	cy Form updated.			Yes □ No □N/A
	5. 000 222 . 20.80				
	4. OCC 1215 Health In	ventory updated.			Yes □ No □N/A
	4. OCC 1215 Health In	ventory updated. ment/Care Plan: Medical/I	Behavioral/IEP/I		
	4. OCC 1215 Health In 5. Individualized Treat			FSP.	Yes □ No □N/A

## Maryland State Department of Education Office of Child Care MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:			Date of Birth:			
Medication Name:			Dosage:			
Route:			Time to Administer:			
DATE ADMINISTERED	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE	
					5	

# Maryland State Department of Education Office of Child Care ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1 CHILD'S NAME (First Middle   2c+)		TATE OF BEING	/ / Varayet of plants and an analysis of the control of the contro		
1000 10		4. DAIE OF BIN	r (min) dd/ yyyy)	//	s. Child's picture (optional)
	Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEATLH CARE PROVIDER	N - MUST BE COMPLETI	ED BY THE HEATL	H CARE PROVIDER	
4. ASTHMA SEVERITY: ☐Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent☐ Exercise Induced ☐Peak Flow Best_	Mild Persistent 🛮 Moderate Persistent	☐ Severe Persistent☐ Exerci	se Induced	ow Best%	
5. ASTHMA TRIGGERS (check all that apply):	□Colds □ URI □ Seasonal Allergies	□Pollen □ Exercise	□Animals □Dust	□Smoke □ Food □We	□Weather □Other
6. This authorization is NOT TO EXCEED 1 YEAR FROM / / TO TO FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216	AR FROM / / TO  ORM IS USED WITHOUT OCC 1216		7. SCI	HOOL AGE ONLY: OK to Self	7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer ☐ Yes ☐ No
GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At		Home unless otherwise indicated	icated		を 日本 と 日本
The Child has <u>ALL</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Breathing is good					
□No cough or wheeze					
☐Can walk, exercise, & play					
☐ ☐ ☐ Can sleep all night					
If known, peak flow greater than (80% personal best)					
☐ CALL 911	☐ CALL PARENT ☐ OTHER:				
□Prior to all exercise/sports	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
Mykow the child feels them and it				inne æ i redaene)	sheda manacions
Livinen the child reels they need it					
YELLOW ZONE - GETTING WORSE	CALL 911 CALL PARENT	□ OTHER:			
The Child has <u>ANY</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Some problems breathing ☐Wheezing, noisy breathing ☐Tight chest					
☐Cough or cold symptoms ☐Shortness of breath ☐Other:					I I
If known, peak flow between and (50% to 79% personal best)					
RED ZONE - MEDICAL ALERT/DANGER	☐ CALL 911 ☐ CALL PARENT	□ OTHER:		W. T. LINE TO SERVICE AND ADDRESS OF THE PARTY OF THE PAR	TOTAL CONTRACTOR OF THE PARTY O
The Child has <u>ANY</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐ Breathing hard and fast☐Lips or fingernails are blue☐ Trouble walking or talking☐ ☐ Medicine is not helping (15-20 mins?)					
☐ Other:☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐					
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# Maryland State Department of Education Office of Child Care

# ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

STATE  STATE  PARENT/GUARDIAN AUTHORIZATION - MUST BE COMPLETED BY THE HEALTH CARE PROVIDER  PARENT/GUARDIAN AUTHORIZATION - MUST BE COMPLETED BY THE PARENT/GUARDIAN  PARENT/GUARDIAN AUTHORIZATION - MUST BE COMPLETED BY THE PARENT/GUARDIAN  PARENT/GUARDIAN AUTHORIZATION - MUST BE COMPLETED BY THE PARENT/GUARDIAN  BAGINALIS, and 13A.18; the child in self-administration as prescribed above. Lertify that I have legal authorized childcare staff and the authorized prescriber indicated on this form to communicate in comp used. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in comp 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer incomp 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer incomp 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer incomp 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer incomp 14A.18; the childcare program may revoke the child's authorization date of Emergy 14A.17, and 13A.18; the childcare program may revoke the child's authorization date of Emergy 15B. ONAR PHONE # 10B. ONAR PHONE # 1	Pace Stamp Here PROVIDER   Pace Stamp Here	CHILD'S NAME (First Middle Last)	: Last)		DATE OF BIRTH (mm/dd/yyyy)	/www)
Prescribers Name/ITITE   Page   Pag	Prescribers Name/Title   FAX   ADDRESS   STATE   ZIP CODE   Sandth Here   Stamp Here   Stamp Here   ADDRESS   STATE   ZIP CODE   Sandth Here   Stamp Here   Sandth Here		Section II. PRESC	CRIBER'S AUTHORIZATIO	N - MUST BE COMPLETED B	Y THE HEALTH CARE PROVIDER
TELEPHONE  ADDRESS  GTY  ADDRESS  GTY  Section III. PARENT/GUARDIAN AUTHORIZATION — MUST BE COMPLETED BY THE PARENT/GUARDIAN  Transmission in the week is well be felled in self-administer on to supervise the held in self-administer on the communicate in compliance with HipAA. I authorize the childran strain and the medication for supervise the childran strain and the authorized paried an authorized paried and subcrised and subcrised paried and subcrised and su	TELEPHONE  ADDRESS  GTY  To propose SIGNATURE (Parant/gaudan cannot sign here)  To grant signature or signature stant on some stant sign here)  To any other stant or signature to right signature or signature or signature or signature to right signature or signature to right signature stant to administration only.  Section III PARENT/GAURDIAN ALTHORIZATION — MUST BE COMPLETED BY THE PARENT/GAURDIAN  1 authorize the childrane at some signature or signature at signature at some signature or signature at signature or signature at some signature or signature and stone signature signature at some signature signature at some signature signature and signature signature signature signature signature signature signature signature signature and signature signature and signature signat	8. PRESCRIBER'S NAME/TI	TE			Place Stamp Here
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STATE   STAT	STATE   2IP CODE	ADDRESS				
9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)    Original Signature or Signature stannown)   Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN   authorize the childrare staff to administration of medical control of the surfavorized above. I certify that I have legal authority to consent to medical treatment for the child named above including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick understand that per COMAR 13A.15, 13A.15, 13A.15, 13A.15, 13A.15, 13A.15, 13A.15, and 13A.15, the childrare staff and the authorized period on this form to communicate in compiliance with HiPAA, I understand that per COMAR 13A.15, 13A.15, and 13A.15, the childrare program may revoke the child's authorization to self-carry/self-administer I ves	Set   PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)   Original signature or signature stamp only     Consignal signature or signature stamp only     Section III   PRERINT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN     Lauthorize the childrare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child amend above, uniquing the administer of medication of the self-cardy/self-administer. In the nedication, otherwise, it will be discarded. I authorize prinder be resident that at the red of the authorized period an authorized and nucleated individual must pick by the medication, otherwise, it will be discarded. I authorize childrane staff and the authorized period perscribed above. I certify that I have legal authority to consent to medical understand that the red of the authorized period perscribed above. I certify that I have legal authority to consent to medical understand that the red of the authorized period perscribed above. I certify such that is a school Age child only: Ok to Self-Cardy/Self-Administer. I vice in the medication of the childrane staff and the authorized period perscribed that the conformation of the childrane staff and the authorized period perscribed that the conformation of the childrane staff and the authorized period perscribed that the conformation of the childrane staff and the authorized period perscribed that the childrane staff and the authorized period to administer medication is available onsite, field trips   Ves.   No.	CITY	STATE	ZIP CODE		
Section III. PARENT/GUARDIAN AUTHORIZATION - MUST BE COMPLETED BY THE PARENT/GUARDIAN   authorize the childcare staff to administration of to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical to the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period and authorized including the administration of medication at the facility. I understand that at the end of the authorized period and authorized including the administration of medication at the facility. I understand that at the end of the authorized period and authorized including the administration of medication at the facility. I understand that at the end of the authorized period authorized period on this form to communicate in the childran authorized period on this form to communicate in communicate in communicate in communicate in communicate in the childran authorized process of the childran authorized indicates the childran authorized process of the childran and alternatives and alternatives. I will be considered a sometime and signatures:    Authorized process of the childran authorized process of the childran authorized process of the childran and signatures:   Authorized process of the childran authorized proc	Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN   I authorize the childrare staff to administer the medication to supervise data above. I cartify that I have legial authority to consent to medical to up the medication, otherwise, it will be discarded. I authorize childrare staff and the authorized before an undorized individual must pick up the medication, otherwise, it will be discarded. I authorize childrare staff and the authorized individual must pick up the medication, otherwise, it will be discarded. I authorize childrare staff and the authorized individual must pick on this form to communicate in compliance with HiPAA. I school Age Child Only. Ox 5 self-Carr/Self-Administer   Tves   No.  10a. PARENT/GUARDIAN SIGNATURE  10b. DATE (mm/dd/ywy)   10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION   10c. HOME PHONE #   10c. HOME PHONE PHON	9a. PRESCRIBER'S SIGNATI (original signature or signa	JRE (Parent/guardian cannot sture stamp only)	t sign here)		9b. DATE (mm/dd/yyyy)
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Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM cation labeled as required by COMAR cation labeled as required by COMAR fied Diet/Exercise Plan: Medical/Behavioral/IEP/IESP field Diet/Exercise Plan: Medical/Behavioral/IEP/IESP carry/Self -administer and self-carry/self-administer program may revoke the child's authorization to self-carry/self-administer program and received to administer medication is available onsite, field trips   Yes   No   N/A    100. INDAIN CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM cation named above was received Expiration date	Section IV. CHILD CARE STAFF USE ONLY — MUST BE COMPLETED BY THE CHILD CARE PROGRAM  Cation labeled as required by COMAR fied Diet/Exercise Plan Glad	up the medication; other	wise, it will be discarded. I a	uthorize childcare staff and	the authorized prescriber indic	ated on this form to communicate in compliance with HIPAA. I
10e. HOME PHONE #   10e. HOME PHONE #   10e. HOME PHONE #   10e. HOME PHONE #   10f. WORK PHONE PHONE #   10f. WORK PHONE PH	106. HOME PHONE #   106. WORK PHONE	understand that per COM School Age Child Only: O	MR 13A.15, 13A.16, 13A.17, at to Self-Carry/Self -Admini	and 13A.18; the childcare pister ☐ Yes ☐ No	rogram may revoke the child's	authorization to self-carry/self-administer medication.
tt[s] Name/Relationship  L Section IV. CHILD CARE STAFF USE ONLY — MUST BE COMPLETED BY THE CHILD CARE PROGRAM  Section IV. CHILD CARE STAFF USE ONLY — MUST BE COMPLETED BY THE CHILD CARE PROGRAM  2. Medication labeled as required by COMAR  3. OCC 12.14 Emergency Form updated  4. OCC 12.15 Health Inventory updated  5. Modified Diet/Exercise Plan  6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP  7. Staff approved to administer medication is available onsite, field trips   Ves   No   N/A    7. Staff approved to administer medication is available onsite, field trips   Ves   No   N/A    7. Staff approved to administer medication is available onsite, field trips   Ves   No   N/A    7. Staff approved to administer medication is available onsite, field trips   Ves   No   N/A    7. Staff approved to administer medication is available onsite, field trips   Ves   No   N/A    7. Staff approved to administer medication is available onsite, field trips   Ves   No   N/A    7. Staff approved to administer medication is available onsite, field trips   Ves   No   N/A    7. Staff approved to administer medication is available onsite, field trips   Ves   No    7. Staff approved to administer medication is available onsite, field trips   Ves   No    8. Decrease of Emergency From the Phone Brook	tt(s)  Name/Relationship  Section IV. CHILD CARE STAFF USE ONLY - MUST BE COMPLETED BY THE CHILD CARE PROGRAM  Ibilities:  Medication named above was received Expiration date  Medication labeled as required by COMAR  Soci 1214 Emergency Form updated  OC 1215 Health Inventory updated  C. Modified Diet/Exercise Plan  C. Modified Diet/Exercise Plan  C. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP  T. Staff approved to administer medication is available onsite, field trips  T. Staff approved to administer medication is available onsite, field trips  T. Staff approved to administer medication is available onsite, field trips  T. Staff approved to administer medication is available onsite, field trips  T. Staff approved to administer medication is available onsite, field trips  T. Staff approved to administer medication is available onsite, field trips  T. Staff approved to administer medication is available onsite, field trips	10a. PARENT/GUARDIAN SI	GNATURE		10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
Ship  IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM  ned above was received Expiration date	Ship  I.V. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM  ned above was received Expiration date	10d. CELL PHONE #		10e. HOME PHONE	- #	10f. WORK PHONE #
IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM  ned above was received Expiration date	IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM  ned above was received Expiration date	Emergency Contact(s)	Name/Relationship			hone Number to be used in case of Emergency
IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM  ned above was received Expiration date	IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM  ned above was received Expiration date	Parent/Guardian 1				
red above was received Expiration date	ned above was received Expiration date	Parent/Guardian 2				
ned above was received Expiration date	ned above was received Expiration date	Emergency 1				
ned above was received Expiration date	ned above was received Expiration date	Emergency 2				
ned above was received Expiration date	ned above was received Expiration date		Section IV. CHI		Y - MUST BE COMPLETED B	Y THE CHILD CARE PROGRAM
gency Form updated  h Inventory updated    Yes   No   N/A     Xercise Plan   Sehavioral/IEP/IFSP   Yes   No   N/A     Yes   No	gency Form updated  I Yes   No   No   No   No   No   No   No   N	Child Care Responsibilities:	200		Yes	ON C
☐ Yes ☐ No  Xercise Plan  Xercise Plan  Xercise Plan: Medical/Behavioral/IEP/IFSP ☐ Yes ☐ No ☐ N/A  To administer medication is available onsite, field trips ☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A  Exercise Plan  Featment/Care Plan: Medical/Behavioral/IEP/IFSP ☐ Yes ☐ No ☐ N/A  To administer medication is available onsite, field trips ☐ Yes ☐ No		3. OCC 1214 Emergency Fo	orm updated	□ Yes □	ON
reatment/Care Plan: Medical/Behavioral/IEP/IFSP	reatment/Care Plan: Medical/Behavioral/IEP/IFSP		5. Modified Diet/Exercise	lory updated Plan	_ Yes	
			6. Individualized Treatmer 7. Staff approved to admir	nt/Care Plan: Medical/Beha nister medication is availab	<u></u>	0 3 d 1 d
		Reviewed by (printed nar	me and signature):			DATE (mm/dd/www)

OCC 1216 A

### Maryland State Department of Education Office of Child Care

### Allergy and Anaphylaxis Medication Administration Authorization Plan

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. This authorization is NOT TO EXCEED 1 YEAR.

Page 1 to be completed by the Authorized Health Care Provider.

FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216

Place Child's Picture Here (optional)

1011/1002110111111							,
CHILD'S NAME:			Date of Bir	th:/	Date o	of plan:	
Child has Allergy to		□Ingestio			Skin Contact □Sting		
Child has had anaphylaxis:	☐ Yes ☐ No						
Child has asthma: ☐ Yes ☐	☐ No (If yes, highe	r chance severe read	ction) Child				
may self-carry medication	: 🗌 Yes 🗌 No						
Child may self-administer	medication: 🗆 Ye	s □ No					
Allergy and A	naphylaxis Sympt	oms			Treatment C	rder	
If child has ingested a food	allergen, been stu	ing by a bee or expo	sed to an	1	ne :Oral /By Mouth	Epinephrine	
allergy trigger				☐ Call Pare	nt	IM Injection	n in Thigh □ Call Parent
				☐ Call 911		□ Call 911	Call Parent
is Not exhibiting or com							
Exhibits or complains of			. 111				
Mouth: itching, tingling,			tunny")				
Skin: hives, itchy rash, sv							
Throat*: difficulty swallo cough	wing ("choking fe	eling"), hoarseness, h	hacking				
Lung*: shortness of brea	th, repetitive coug	hing, wheezing					
Heart*: weak or fast puls	se, low blood pres	sure, fainting, pale, b	olueness				
Gut: nausea, abdominal	cramps, vomiting,	diarrhea					
Other:							
If reaction is progressing (s	several of the abo	ve areas affected)					
*Potentially life thre	eatening. The seve	rity of symptoms car	n quickly cha	inge*			
Medication	Medication: Br	and and Strength	Dose		Route	Frequ	ency
Epinephrine(EpiPen)							
Antihistamine							
Other:							
EMERGENCY Respon			1 1				
1) Inject epinephr		ote time when epine epinephrine. Advise				av with child	
		time that epinephris				ay with tima.	
		f the child vomits or				de.	
	icine, if prescribed		nas trouble	bi catiling, pia	oc cima on maj noi oi	u.	
PRESCRIBER'S NAME/TITLE	ionia) ii praeeniee			404	Place	stamp here	
THESCHISER'S MAINLY THEE							
TELEPHONE		FAX					
ADDRESS							
				A.			
PRESCRIBER'S SIGNATUR	E (Parent/guardia	n cannot sign here) (	original sign	ature or signat	ure stamp only)	DATE (mm,	/dd/yyyy)

### Maryland State Department of Education Office of Child Care

### Allergy and Anaphylaxis Medication Administration Authorization Plan

Child's Nam	ne:			Date	of Birth:	\ <u></u>	
				UARDIAN AUTHORIZA			
I certify that I ha medication at th otherwise, it will compliance with	ve e f b	rized child care staff to ac legal authority to consen acility. I understand that e discarded. I authorize c IPAA. I understand that p n to self-carry/self-admin	t to medical tre at the end of th hild care staff a er COMAR 13A.	atment for the child n e authorized period a nd the authorized pres .15, 13A.16, 13A.17, a	amed abo n authoris scriber in	ove, including the admi zed individual must pich dicated on this form to	nistration of cup the medication; communicate in
PARENT/GUARDIAN	1 5	SIGNATURE		DATE (mm/dd/yyyy)	INDIVI	DUALS AUTHORIZED TO	PICK UP MEDICATION
CELL PHONE #			HOME PHONE	#		WORK PHONE #	
Emergency Contact(s)	- I Name/Relationship			Phone Number to be used in case o		ase of Emergency	
Parent/Guardian	1						
Parent/Guardian	2						
Emergency 1							
Emergency 2							
	W		Se	ction IV. CHILD CARE	STAFF US	E ONLY	
Child Care	1	. Medication named abov	e was received			☐ Yes ☐ No	
Responsibilities:	2	. Medication labeled as re	equired by COM	AR		☐ Yes ☐ No	
	3	. OCC 1214 Emergency Ca	rd updated			☐ Yes ☐ No	
	4	. OCC 1215 Health Invent	ory updated			☐ Yes ☐ No	
	5	. Modified Diet/Exercise F	Plan			☐ Yes ☐ No ☐N/A	4
		. Individualized Plan: IEP/				☐ Yes ☐ No ☐N/A	
		. Staff approved to admin		n is available onsite, fie	eld trips	☐ Yes ☐ No	
Reviewed by (prin	nte	ed name and signature)					DATE (mm/dd/yyyy)
	_						
		DO	CUMENT MED	ICATION ADMINIST	RATION	HERE	

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

### MARYLAND STATE DEPARTMENT OF EDUCATION OFFICE OF CHILD CARE

### Seizure/Convulsion/Epilepsy Disorder Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. This authorization is NOT TO EXCEED 1 YEAR.

Page 1 is to be completed by the authorized Health Care Provider.

FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

Place Child's Picture Here (Optional

CHILD'S NAME:			Date of Bi	th:/		Date of Plan:
Significant Medical/Health History:_						
Seizure Triggers or Warning Signs:						
Allergies:						
Seizure Care Information						
Seizure Type	Length (durati	on)	Frequen	су	Descript	tion
Seizure Emergency Protocol: How to r	espond to a sei	zure (Che	ck all that	apply)		-
First Aid – Stay. Safe. Side (refer						
Call 911 for transport to						
Notify Health Care Provider				Other		
Administer emergency medication						
Medication Name & Strength	Dosage	Route/	Method	Time & Fre	equency	Special Instructions
Care after seizure: Does the child n	eed to leave t	he classr	oom afte	r a seizure?	☐ Yes ☐	No
What type of help is needed? (desc	ribe)					
When can the child return to care/	resume regula	r activity	/?			
Special Considerations and Precaut	ions (regardin	g activiti	es, sports	, trips, etc.)		
PRESCRIBER'S NAME/TITLE						Place stamp here
	· ·			_		
TELEPHONE	FAX					
ADDRESS				7		
PRESCRIBER'S SIGNATURE (origina	l signature or si	gnature s	tamp only	DATE (	mm/dd/yy	ууу)

### MARYLAND STATE DEPARTMENT OF EDUCATION OFFICE OF CHILD CARE

### Seizure/Convulsion/Epilepsy Disorder Medication Administration Authorization Form

Child's Name:_		Date of	Birth:	
	PARENT/G	UARDIAN AUTHORIZA	TION	
medical treatment	ld care staff to administer the medication for the child named above, including the riod an authorized individual must pick up d prescriber indicated on this form to com	administration of med the medication; other	dication at the facility. I und rwise, it will be discarded.	lerstand that at the end of
PARENT/GUARDIAN	SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZI	ED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE	#	WORK PHONE #	
Emergency Contact(s)	Name/Relationship		Phone Number to be used	d in case of Emergency
Parent/Guardian 1				
Parent/Guardian 2				
Emergency 1				
Emergency 2				
	CHILD	CARE STAFF USE ONI	Υ.	
Responsibilities:	I. Medication named above was received.  2. Medication labeled as required by COM.  3. OCC 1214 Emergency Form updated.  4. OCC 1215 Health Inventory updated.  5. Staff has received additional training to If Yes: Trainer Name and Title  5. Staff approved to administer medication.  7. Modified Diet/Exercise Plan.  8. Individualized Treatment/Care Plan: Medication.	administer the medican	Yes	
Reviewed by (print	ed name and signature):			DATE (mm/dd/yyyy)

### **DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE
				1		
				1		
				+		