

**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)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: ____/____/____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: ____/____/____ to ____/____/____

If PRN, for what symptoms, how often and how long _____

Possible side effects and special instructions: _____

Known Food or Drug Allergies: Yes No If yes, please explain: _____

For School Age children only: The child may self-carry this medication: Yes No

The child may self-administer this medication: Yes No

PRESCRIBER'S NAME/TITLE

Place Stamp Here (Optional)

TELEPHONE

FAX

ADDRESS

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the 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 up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer** Yes No

PARENT/GUARDIAN SIGNATURE

DATE (mm/dd/yyyy)

INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

CELL PHONE #

HOME PHONE #

WORK PHONE #

CHILD CARE STAFF USE ONLY

- | | | |
|------------------------------|---|---|
| Child Care Responsibilities: | 1. Medication named above was received. Expiration date _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 2. Medication labeled as required by COMAR. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 3. OCC 1214 Emergency Form updated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | 4. OCC 1215 Health Inventory updated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | 5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | 6. Staff approved to administer medication is available onsite, field trips | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Reviewed by (printed name and signature):

DATE (mm/dd/yyyy)

**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

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last) _____ 2. DATE OF BIRTH (mm/dd/yyyy) ____/____/____ 3. Child's picture (optional)

Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

4. ASTHMA SEVERITY: Mild Intermittent Moderate Persistent Severe Persistent Exercise Induced Peak Flow Best ____ %
 5. ASTHMA TRIGGERS (check all that apply): Colds URI Seasonal Allergies Pollen Exercise Animals Dust Smoke Food Weather Other _____
 6. This authorization is NOT TO EXCEED 1 YEAR FROM ____/____/____ TO ____/____/____
 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

The Child has <u>ALL</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night If known, peak flow greater than _____ (80% personal best)					

Exercise Zone CALL 911 CALL PARENT OTHER:

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it				

YELLOW ZONE - GETTING WORSE CALL 911 CALL PARENT OTHER:

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
The Child has <u>ANY</u> of these <input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ If known, peak flow between _____ and _____ (50% to 79% personal best)				

RED ZONE - MEDICAL ALERT/DANGER CALL 911 CALL PARENT OTHER:

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
The Child has <u>ANY</u> of these <input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ If known, peak flow below _____ (0% to 49% personal best)				

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

CHILD'S NAME (First Middle Last)

DATE OF BIRTH (mm/dd/yyyy) ____/____/____

Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

8. PRESCRIBER'S NAME/TITLE

Place Stamp Here

TELEPHONE

FAX

ADDRESS

CITY

STATE

ZIP CODE

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)
(original signature or signature stamp only)

9b. DATE (mm/dd/yyyy)

Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN

I authorize the childcare 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 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 up the medication; otherwise, it will be discarded. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.

School Age Child Only: **OK to Self-Carry/Self-Administer** Yes No

10a. PARENT/GUARDIAN SIGNATURE

10b. DATE (mm/dd/yyyy)

10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

10d. CELL PHONE #

10e. HOME PHONE #

10f. WORK PHONE #

Emergency Contact(s)

Name/Relationship

Phone Number to be used in case of Emergency

Parent/Guardian 1

Parent/Guardian 2

Emergency 1

Emergency 2

Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM

Child Care Responsibilities:

1. Medication named above was received Expiration date _____ Yes No
2. Medication labeled as required by COMAR Yes No
3. OCC 1214 Emergency Form updated Yes No
4. OCC 1215 Health Inventory updated Yes No
5. Modified Diet/Exercise Plan Yes No N/A
6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP Yes No N/A
7. Staff approved to administer medication is available onsite, field trips Yes No

Reviewed by (printed name and signature):

DATE (mm/dd/yyyy)

**Allergy and Anaphylaxis
Medication Administration Authorization Plan**

Place Child's Picture
Here (optional)

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

CHILD'S NAME: _____ Date of Birth: ____/____/____ Date of plan: _____
Child has Allergy to _____ Ingestion/Mouth Inhalation Skin Contact Sting Other _____
Child has had anaphylaxis: Yes No
Child has asthma: Yes No (If yes, higher chance severe reaction) Child
may self-carry medication: Yes No
Child may self-administer medication: Yes No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth <input type="checkbox"/> Call Parent <input type="checkbox"/> Call 911	Epinephrine(EpiPen) IM Injection in Thigh <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parent
is Not exhibiting or complaining of any symptoms, OR		
Exhibits or complains of any symptoms below:		
Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Other:		
If reaction is progressing (several of the above areas affected)		

Potentially life threatening. The severity of symptoms can quickly change

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

EMERGENCY Response:

- 1) **Inject epinephrine right away! Note time when epinephrine was administered.**
- 2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) **DATE** (mm/dd/yyyy)

Maryland State Department of Education
Office of Child Care
Allergy and Anaphylaxis
Medication Administration Authorization Plan

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION			
<p>I request the authorized child care 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 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 up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.</p>			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
Section IV. CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Card updated 4. OCC 1215 Health Inventory updated 5. Modified Diet/Exercise Plan 6. Individualized Plan: IEP/IFSP 7. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION 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 Birth: ___/___/___ Date of Plan: _____

Significant Medical/Health History: _____

Seizure Triggers or Warning Signs: _____

Allergies: _____

Seizure Care Information

Seizure Type	Length (duration)	Frequency	Description

Seizure Emergency Protocol: How to respond to a seizure (Check all that apply)

- First Aid – Stay. Safe. Side (refer to resource document “Seizure First Aid Guide”)
 Call 911 for transport to _____ Notify parent or emergency contact
 Notify Health Care Provider _____ Other _____
 Administer emergency medications as indicated below:

Medication Name & Strength	Dosage	Route/Method	Time & Frequency	Special Instructions

Care after seizure: Does the child need to leave the classroom after a seizure? Yes No

What type of help is needed? (describe) _____

When can the child return to care/resume regular activity? _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (original signature or signature stamp only)		DATE (mm/dd/yyyy)

**MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure/Convulsion/Epilepsy Disorder
Medication Administration Authorization Form**

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION			
I authorize the child care staff to administer the medication as prescribed above. I certify that I have the 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 up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #		HOME PHONE #	WORK PHONE #
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received. Expiration Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	2. Medication labeled as required by COMAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. OCC 1214 Emergency Form updated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	5. Staff has received additional training to administer the medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
	If Yes: Trainer Name and Title _____	Date _____	
	6. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
	8. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE