

**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					
<p>I request the authorized 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.</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					
CHILD CARE STAFF USE ONLY					
<p>Child Care Responsibilities:</p> <ol style="list-style-type: none"> 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. Staff has received additional training to administer the medication 6. Staff approved to administer medication is available onsite, field trips 7. Modified Diet/Exercise Plan 8. Individualized Plan: IEP/IFSP 	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>If Yes: Trainer Name and Title _____ Date _____</p> </td> <td style="width: 50%; vertical-align: top;"> <p> <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 <input type="checkbox"/> N/A </p> </td> </tr> </table>			<p>If Yes: Trainer Name and Title _____ Date _____</p>	<p> <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 <input type="checkbox"/> N/A </p>
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Reviewed by (printed name and signature): _____		DATE (mm/dd/yyyy) _____			

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED	SIGNATURE