

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

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:

Emergency Medication	Dosage	Route/Method	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)