

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

Place Child's
Picture Here
(optional)

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.

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 ____	☐ Yes ☐ No
	2. Medication labeled as required by COMAR.	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated.	☐ Yes ☐ No ☐ N/A
	4. OCC 1215 Health Inventory updated.	☐ Yes ☐ No ☐ N/A
	5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP.	☐ Yes ☐ No ☐ N/A
	6. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ 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

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

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 is to be completed by the authorized Health Care Provider.
FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

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 _____ 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Form updated 4. OCC 1215 Health Inventory updated 5. Staff has received additional training to administer the medication If Yes: Trainer Name and Title _____ 6. Staff approved to administer medication is available onsite, field trips 7. Modified Diet/Exercise Plan 8. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ N/A Date _____ ☐ Yes ☐ No ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A
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Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE

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)

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 Call Parent Call 911	 Name of Epinephrine Medication Call 911 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 Medication				
Antihistamine				
Other:				

EMERGENCY Response:

- 1) **Administer 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.

Emergency use epinephrine medication may include auto-injector(injectable) or non-injectable-nasal spray ready to use medication approved by FDA and prescribed by licensed health care provider.

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

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.

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 ☐ Yes ☐ No 2. Medication labeled as required by COMAR ☐ Yes ☐ No 3. OCC 1214 Emergency Card updated ☐ Yes ☐ No 4. OCC 1215 Health Inventory updated ☐ Yes ☐ No 5. Modified Diet/Exercise Plan ☐ Yes ☐ No ☐ N/A 6. Individualized Plan: 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)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	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 FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216																						
GREEN ZONE DOING WELL: Long Term Control Medication Use Daily At Home unless otherwise indicated																						
<table border="1"> <thead> <tr> <th>The Child has ALL of these</th> <th>Medication Name & Strength</th> <th>Dose</th> <th>Route</th> <th>Time & Frequency</th> <th>Special Instructions</th> </tr> </thead> <tbody> <tr> <td rowspan="2"> ☐ Breathing is good ☐ No cough or wheeze ☐ Can walk, exercise, & play ☐ Can sleep all night If known, peak flow greater than _____ (80% personal best) </td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						The Child has ALL 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)										
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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			
Place Stamp Here			
8. PRESCRIBER'S NAME/TITLE			
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		
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)	

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

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	DATE	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE