MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child Care Program: ____________________________

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Parent/Guardian must bring the medication to the facility.
- Must pick up the medication at the end of authorized period, otherwise it will be discarded.

PREScriBER’S AUTHORIZATION

Child’s Name: ____________________________ Date of Birth: ____________________________

Condition for which medication is being administered: ____________________________

Medication Name: ____________________________ Dose: ____________________________ Route: ____________________________

Time/frequency of administration: ____________________________ If PRN, frequency: ____________________________

If PRN, for what symptoms: ____________________________

Possible side effects & special instructions: ____________________________

Medication shall be administered from: ____________________________ to ____________________________

Known Food or Drug: Allergies? Yes No If Yes, please explain ____________________________

Prescriber’s Name/Title: ____________________________ (Type or print)

Telephone: ____________________________ FAX: ____________________________

Address: ____________________________

Prescriber’s Signature: __________________________________ Date: ____________________________

(Original signature or signature stamp ONLY)

This space may be used for the Prescriber’s Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: ____________________________ Date: ____________________________

Home Phone #: ____________________________ Cell Phone #: ____________________________ Work Phone #: ____________________________

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of emergency medication noted above may be authorized by the prescriber.

Prescriber’s authorization: ____________________________ Signature Date

Parental approval: ____________________________ Signature Date

FACILITY RECEIPT AND REVIEW

Medication was received from: ____________________________ Date: ____________________________

Special Health Care Plan Received: ☐ YES ☐ NO

Medication was received by: ____________________________

Signature of Person Receiving Medication and Reviewing the Form Date

OCC 1216 (Revised 08/20/15) – All previous editions are obsolete.)
MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child’s record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child’s record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child’s parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child’s overall record. Keep this form in the child’s permanent record while the child remains in the care of this provider or facility.

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Medication Name:</td>
<td>Dosage:</td>
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<tr>
<td>Route:</td>
<td>Time(s) to administer:</td>
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<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>DOSAGE</th>
<th>REACTIONS OBSERVED (IF ANY)</th>
<th>SIGNATURE</th>
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