Parent, provider, & Healthcare Provider must sign and date.	**Maryland State Department of Education/Office of Child Care** **Child Care Scholarship Program** **INFORMAL PROVIDER** **EMERGENCY CARE & MEDICATION AUTHORIZATION**	**Return to:** informalcare.msde@maryland.gov

If you need assistance completing this form, call CCS Central at 1-866-243-8796

Instructions to Parent/Guardian & Informal Provider

(1) Please complete Sections 1, 2, & 3;
(2) Review Sections 4 & 5 once completed by the child's healthcare provider;
(3) Complete, sign, and date Section 6 if applicable (parent only). If not applicable, enter N/A;
(4) Complete, sign, and date Section 7.

Prepare and keep up-to-date this Emergency Care & Medical Authorization Form. Have the child's healthcare provider complete Section 4 and Section 5. The Parent/Guardian should coordinate, review, and discuss the details with the Informal Provider. If medications are needed, the Parent/Guardian will provide them as appropriate. They will keep the Informal Provider up-to-date regarding any special instructions or needed medications; ensuring the medication is available during child care and is stocked in the Emergency Preparedness Kit (aka Emergency Ready-to-Go-Pack) as appropriate.

An Emergency Care & Medication Authorization Form, completed, dated, and signed, is required at initial application, each informal provider renewal, and at any medical or medication prescription change.

Section 1 Child & Parent

Child's Information

First Name:	Last Name:	Date of Birth:
Home Location: Street Address	City County State Zip Code	

Parent/Guardian Information

First Name:	Last Name:	Relationship:
Work Telephone:	Cell Telephone:	Home Telephone:
Place of Employment:		

Section 2 Informal Provider

First Name:	Last Name:	Relationship:
Street Address	City County State Zip Code	

Section 3 Child's Healthcare Provider

First Name:	Last Name:	Telephone:
Practice Name:		
Office Location: Street Address/Suite #	City County State Zip Code	

Note – In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person (Informal Provider) to have your child transported to that hospital.

Instructions to Healthcare Provider

(1) Please complete Section 4. If not applicable indicate N/A.
(2) Complete, sign and date Section 5.

Section 4 Child's Health Emergency & Medical Information

(required - if not applicable indicate N/A)

List Allergies & Reactions:

1) Signs & symptoms to look for:

2) If signs & symptoms appear, do this:

3) To prevent incidents, do this:

Date of child's last tetanus shot:

Medical Condition(s)

Medications currently prescribed to the child:

Medication Name:	Dosage	Time/Freq.	Route/method	Possible Side Effects	Special Instructions

Special healthcare needs:

Section 5 Healthcare Provider Signature

Name/Title:

Office Location: Street Address/Suite # City County State Zip Code

Printed Name:	Telephone:
Signature:	Date:

Section 6 Parent/Guardian Medication Authorization

(required - if not applicable indicate N/A)

I request that my Informal Provider administer the medication as noted by the healthcare provider 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 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 instructions and demonstrate medication administration procedures to the informal child care provider.

Parent/Guardian Signature:	Date:

Section 7 Signature & Date

I attest that information provided on this form is true and accurate to the best of my knowledge and belief. A new form will be submitted as appropriate, such as with medication changes. I will report any communicable diseases to my local health department.

PARENT		INFORMAL PROVIDER	
Printed Name:		Printed Name:	
Signature:		Signature:	
Date:	Phone:	Date:	Phone:

The Emergency Care & Medication Authorization Form must be signed and dated, by the Parent, Informal Provider, and Healthcare Provider, to be processed. Electronic signatures are not acceptable.