MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure Medication Administration Authorization Form

Name of Child Care Facility ______________________________________________________

This form authorizes emergency seizure care for ____________________________ □ M □ F
(Child’s Name) (Date of Birth)
while attending the above named child care facility during child care hours. This form must be completed by the
child’s physician and signed by both physician and parent.

Treating Physician ___________________________________ Phone# ____________________ # After Hours ______

Significant Medical History: ______________________________________________________

Seizure Care Information

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
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Seizure Triggers or Warning Signs: ______________________________________________________

Seizure Emergency Protocol (Check all that apply and clarify below)

☐ Call 911 for transport to ____________________________________________ ☐ Notify parent or emergency contact
☐ Notify treating physician ____________________________________________ ☐ Other

☐ Administer emergency medications as indicated below:

<table>
<thead>
<tr>
<th>Emergency Medication</th>
<th>Dosage</th>
<th>Time</th>
<th>Route/method</th>
<th>Side Effects</th>
<th>Special Instructions</th>
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<tbody>
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Does child need to leave the classroom after a seizure? ☐ Yes ☐ No  If YES, describe process for returning the child to
the classroom. ________________________________________________________________

Special Considerations and Precautions (regarding activities, sports, trips, etc.) ____________________________________________________________

Physician Signature: ___________________________________________ Date: __________________

Parent Information & Authorization: Medications must be in the original container and labeled with the child’s name,
name of medication, directions for medication’s administration, and date of the prescription. I request that medication
be administered to my child as described and directed above and attest that I have administered at least one dose of the
medication to my child without adverse effects. I agree to review special instruction and demonstrate the medication
administration procedure to the child care provider. I understand the risk and authorize for administration of
emergency seizure medication to my child.

Parent/Guardian Signature: ___________________________________________ Date: __________________

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