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.

Child's Picture (Optional)

PRESCRIB	IBER'S AUTHORIZATION			
Child's Name:	Date of Birth:			
Condition for which medication is being administered:				
Medication Name:	Dose:Route:			
	If PRN, frequency:(PRN=as needed)			
If PRN, for what symptoms:	(FRIV-as needed)			
Possible side effects &special Instructions:				
Medication shall be administered from:	to			
Known Food or Drug: Allergies? Yes No If Yes, please ex				
Prescriber's Name/Title:(Type or print)				
Telephone: FAX: Address:				
Prescriber's Signature: (Original signature or signature stamp ONLY)				
(Original signature or <u>signature</u> stamp ONLY)	Y) This space may be used for the Prescriber's Address St			
isk and consent to medical treatment for the child named above, and demonstrate medication administration procedure to the chil				
Parent/Guardian Signature:				
Home Phone #:Cell Phone #:	Work Phone #:			
(Only school-aged children may	OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL ay be authorized to self carry/self administer medication.)			
Prescriber's authorization:Signature Parental approval:	oted above may be authorized by the prescriber. Date			
Prescriber's authorization: Signature Parental approval: Signature	Date			
Prescriber's authorization: Signature Parental approval: Signature	oted above may be authorized by the prescriber. Date			
Prescriber's authorization: Parental approval: Signature Signature FACILITY	Date Date Date TY RECEIPT AND REVIEW			
Prescriber's authorization: Parental approval: Signature Signature FACILITY Medication was received from:	Date Date Date TY RECEIPT AND REVIEW			

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.

Child's Name: Medication Name:				Date of Birth: Dosage:			
Route:				Time(s) to administer:			
DATE	TIME	DOSAGE	REACTIONS OF	BSERVED (IF ANY)	SIGNATURE		
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Must be	Allergy Action accompanied by a Medication		1216)		
CHILD'S NAME:		Place Child's			
ALLERGY TO:					
Is the child Asthmat	ic? No Yes (If Yes = H	ligher Risk for Severe Reactio	n)		
TREATMENT					
Symptoms:		H		is Medication	
	ted a food allergen or exposed to a ng or complaining of any symptom		Epinephrine	Antihistamin	
	gling, swelling of lips, tongue or m				
•	rash, swelling of the face or extren				
A SEC SECTION OF THE PROPERTY	ominal cramps, vomiting, diarrhea				
	swallowing ("choking feeling"), hos				
•	of breath, repetitive coughing, whe				
•	ast pulse, low blood pressure, faint				
Other:	ist pulse, low blood pressure, raint	ing, paic, bidefiess			
	ssing (several of the above areas	affected)			
	atening. The severity of symptom				
	nhalers and/or antihistamines cannot be de		anaphylaxis.		
Medication			Dose:		
Epinephrine:		1			
Antihistamine:					
Other:					
Doctor's Signature			Date		
EMERGENCY CAL		e has been administered. 2) Co may be needed. 3) Stay with t		te that an allergic	
	eated a <mark>nd</mark> additional epinephrine				
reaction has been to		PI	hone Number:		
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Contact(s) Parent/Guardian 1 Parent/Guardian 2 Emergency 1 Emergency 2	Name/Relationship	Daytime REACHED, DO NOT HESITATE TO Parent Authorization for Self/Carry Self Administrat	Phone Numb Number	er(s) Cell NLL 911.	

Triggers (list) Maryland State Child Care/Nursery School Asthma Medication Administration Authorization Form ASTHMA ACTION PLAN for ___/___ to ___/____ (not to exceed 12 months) PREPARING WORLD CLASS STUDENTS Student's DOB: PEAK FLOW PERSONAL BEST: Name: ASTHMA SEVERITY: Exercise Induced Intermittent Mild Persistent Moderate Persistent Severe Persistent GREEN ZONE: Long Term Control Medication — use daily at home unless otherwise indicated. Medication Dose Route Frequency ☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other: _____ ☐ Peak flow greater than _____(80% personal best) (Rescue Medication) □ Prior to exercise/sports/ physical education If using more than twice per week for exercise, notify the health care provider and parent/guardian. YELLOW ZONE. Quick Relief Medications -- to be added to Green zone medications for symptoms ☐ Cough or cold symptoms Medication Dose Route Frequency ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night □ Other: ☐ Peak flow between _____ and _____ If symptoms do not improve in minutes, notify the health care provider and parent/guardian. (50%-79% personal best) If using more than twice per week, notify the health care provider and parent/guardian. ALD SOME Emergency Machiner with Charlest and There is the State of th ☐ Medication is not helping within 15-20 mins Medication Dose Route Frequency ☐ Breathing is hard and fast ☐ Nasal flaring or skin retracts between ribs ☐ Lips or fingernails blue ☐ Trouble walking or talking ☐ Peak flow less than ______(50% personal best) | Contact the parent/guardian after calling 911. Health Care Provider and Parent Authorization Lauthorize the child care provider to administer the above medications as indicated. By signing below, Lauthorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications: [School-age children] \ \Po Yes \ \ \Po No Prescriber signature: ______ Date: _____ Parent / Guardian Signature: ______ Date: _____ Date: _____ Reviewed by Child Care Provider: Name: _____ Signature: _____ Date: _____

3/20/2014

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	(Child's Name)	(Date of Birth)
while attending the a child's physician and				child care nou	rs. This form must be completed by the
Treating Physician _			р	hone#	# After Hours
Significant Medical	History:				
			Seizure Care		
Seizure Type	Seizure Type Length		Frequ	ency	Description
Coinura Triggars or W	orning Sigr	ve.			
Seizure miggers or w	arming Jigi	13.			
Seizure Emergency Prot	ocol (Check	all that a	pply and clarify belo	w)	
☐ Call 911 for transpo	ort to			7 04-	Notify parent or emergency contact
				Other	
		ncy medications as indicated below: Dosage Time Route/method Side Effects Special Instructions			Special Instructions
Medication					
Does child need to lea	ve the clas	sroom at	⊥ fter a seizure? ☐ Y	es No If YES	5, describe process for returning the child to
the classroom.					
Special Considerations	s and Preca	autions (r	egarding activities,	, sports, trips, e	etc.)
	AAA AMARIN AA				
Physician Signature:				angang nganati maja an nambahili na kandadan alkapadan di kahaja di sanagan nya padamahili	Date:
name of medication, of be administered to my medication to my chile	directions f y child as d d without a lure to the	or medic escribed adverse e child car	ation's administrat and directed abov affects. I agree to r e provider. I unde	tion, and date on e and attest the eview special in	container and labeled with the child's name, of the prescription. I request that medication at I have administered at least one dose of the instruction and demonstrate the medication and authorize for administration of
Parent/Guardian Sign	ature:				Date:
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