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

Child's Picture (Optional)

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: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions: _____

Medication shall be administered from: _____ to _____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

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 Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date

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:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to administer:**

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
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		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*__IMPORTANT:__ Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

_____ _____
Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

_____ _____
Parent/Guardian's Signature Date

Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

Triggers (list)
_____
_____
_____
_____
_____
_____
_____

Student's
Name:_____ DOB:_____ PEAK FLOW PERSONAL BEST:_____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE: Long Term Control Medication — use daily at home unless otherwise indicated

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than _____ (80% personal best)

Medication	Dose	Route	Frequency
(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
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____

Medication	Dose	Route	Frequency

☐ Peak flow between _____ and _____ (50%-79% personal best)

If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE: Emergency Medication — Take these medications and call 911

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other:_____
☐ Peak flow less than _____ (50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize 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) ☐Yes ☐No

Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ 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 _____ ❒ 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

Seizure Type	Length	Frequency	Description

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:

Emergency Medication	Dosage	Time	Route/method	Side Effects	Special Instructions

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:** _____