**Maryland State Department of Education**
**Office of Child Care**

# Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
**This form is required for both prescription and non-prescription/over-the-counter (OTC) medications.**
**Prescription medication must be in a container labeled by the pharmacist or prescriber.**
**Non-prescription/OTC medication must be in the original container with the label intact per COMAR.**

Place Child's Picture Here (optional)

## PRESCRIBER'S AUTHORIZATION

**Child's Name**:_____Date of Birth: ____/_____/_____

| Medication and Strength | Dosage | Route/Method | Time & Frequency | Reason for Medication |
|---|---|---|---|---|
| | | | | |

Medications shall be administered from:____/____/_____ to ____/____/_____

If PRN, for what symptoms, how often and how long_____

Possible side effects and special instructions:_____

Known Food or Drug Allergies: ☐ Yes ☐No If yes, please explain:_____

For School Age children only: The child may self-carry this medication: ☐ Yes ☐No

The child may self-administer this medication: ☐ Yes ☐No

| PRESCRIBER'S NAME/TITLE | | Place Stamp Here (Optional) |
|---|---|---|
| TELEPHONE | FAX | |
| ADDRESS | | |

**PRESCRIBER'S SIGNATURE** (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

## PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed 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 the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer ☐ Yes ☐ No**

| PARENT/GUARDIAN SIGNATURE | DATE (mm/dd/yyyy) | INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION |
|---|---|---|
| CELL PHONE # | HOME PHONE # | WORK PHONE # |

## CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received. Expiration date _____ ☐ Yes ☐ No
2. Medication labeled as required by COMAR. ☐ Yes ☐ No
3. OCC 1214 Emergency Form updated. ☐ Yes ☐ No ☐N/A
4. OCC 1215 Health Inventory updated. ☐ Yes ☐ No ☐N/A
5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. ☐ Yes ☐ No ☐N/A
6. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No

| Reviewed by (printed name and signature): | DATE (mm/dd/yyyy) |
|---|---|

## Maryland State Department of Education
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## MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

| **Child's Name**: | | | | **Date of Birth:** | |
|---|---|---|---|---|---|
| **Medication Name:** | | | | **Dosage:** | |
| **Route:** | | | | **Time to Administer:** | |
| **DATE ADMINISTERED** | **TIME** | **DOSAGE** | **ROUTE** | **REACTIONS OBSERVED (IF ANY)** | **SIGNATURE** |
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