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)

DDECCRIPED/C ALITHODIZATION										
PRESCRIBER'S AUTHORIZATION										
Child's Name:		Date of Birth:/								
Medication and Strength	Dosage	Route/Method	Tir	me & Frequency	Reason for Medication					
		L								
Medications shall be administered from:/ to/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 med	dication or to super	rvise the child in		as prescribed above. I					
attest that I have administered a	administer the med	dication or to super the medication to r	rvise the child in my child without	adverse effects. I	as prescribed above. I certify that I have the legal					
attest that I have administered a authority to consent to medical	administer the med at least one dose of treatment for the ch	dication or to super the medication to r nild named above, i	rvise the child in my child without including the adr	adverse effects. I deministration of med	as prescribed above. I certify that I have the legal lication at the facility. I					
attest that I have administered a authority to consent to medical understand that at the end of th	administer the med at least one dose of treatment for the ch ae authorized period	dication or to super the medication to r nild named above, i an authorized indi	rvise the child in my child without including the adr vidual must pick	adverse effects. I deministration of med to the medication	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be					
attest that I have administered a authority to consent to medical understand that at the end of th discarded. I authorize child care	o administer the med at least one dose of treatment for the ch are authorized period e staff and the autho	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind	rvise the child in my child without including the adrividual must pick dicated on this fo	adverse effects. I deministration of med to the medication orm to communicat	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with					
attest that I have administered a authority to consent to medical understand that at the end of th	administer the med at least one dose of treatment for the ch e authorized period e staff and the autho DMAR 13A.15, 13A.1	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A	rvise the child in my child without including the adrividual must pick dicated on this follows.	adverse effects. I deministration of med to the medication orm to communicate program may rev	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with voke the child's					
attest that I have administered a authority to consent to medical understand that at the end of th discarded. I authorize child care HIPAA. I understand that per CO	administer the med at least one dose of treatment for the ch e authorized period e staff and the autho DMAR 13A.15, 13A.1	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A	rvise the child in my child without including the adrividual must pick dicated on this follows, the child call only: OK to Selection	adverse effects. I deministration of med to the medication orm to communicate program may rev	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with woke the child's inister					
attest that I have administered a authority to consent to medical understand that at the end of th discarded. I authorize child care HIPAA. I understand that per CO authorization to self-carry/self-a	administer the med at least one dose of treatment for the ch e authorized period e staff and the autho DMAR 13A.15, 13A.1	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A on. School Age Chil	rvise the child in my child without including the adrividual must pick dicated on this follows, the child call donly: OK to Solvy)	adverse effects. I deministration of med to up the medication orm to communication program may revell—Carry/Self-Adm	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with woke the child's inister					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CO authorization to self-carry/self-a	administer the med at least one dose of treatment for the ch e authorized period e staff and the autho DMAR 13A.15, 13A.1	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A on. School Age Chil DATE (mm/dd/yyy	rvise the child in my child without including the adrividual must pick dicated on this follows, the child call donly: OK to Solvy)	adverse effects. I deministration of med to up the medication orm to communication program may revelf-Carry/Self-Administration of the communication of the	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with woke the child's inister Yes No					
attest that I have administered a authority to consent to medical understand that at the end of th discarded. I authorize child care HIPAA. I understand that per CO authorization to self-carry/self-a	administer the med at least one dose of treatment for the ch e authorized period e staff and the autho DMAR 13A.15, 13A.1	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A on. School Age Chil	rvise the child in my child without including the adrividual must pick dicated on this follows, the child call donly: OK to Solvy)	adverse effects. I deministration of med to up the medication orm to communication program may revell—Carry/Self-AdmovIDUALS AUTHORIZ	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with woke the child's inister Yes No					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CC authorization to self-carry/self-a PARENT/GUARDIAN SIGNATURE CELL PHONE #	o administer the med at least one dose of treatment for the ch re authorized period e staff and the autho DMAR 13A.15, 13A.1 administer medication	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A on. School Age Chil DATE (mm/dd/yyy	rvise the child in my child without including the adrividual must pick dicated on this follows. A.18, the child call donly: OK to Servi) MED	adverse effects. To ministration of med to up the medication orm to communication program may reveled. Carry/Self-Administration of the medication of the me	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be se in compliance with woke the child's inister Yes No					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CC authorization to self-carry/self-are PARENT/GUARDIAN SIGNATURE CELL PHONE #	o administer the med at least one dose of treatment for the ch re authorized period e staff and the autho DMAR 13A.15, 13A.1 administer medication	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A on. School Age Chil DATE (mm/dd/yyy	rvise the child in my child without including the adrividual must pick dicated on this following. OK to Solvy) USE ONLY	adverse effects. To ministration of med to up the medication orm to communication program may revelf-Carry/Self-Administration of the medication orm to communication or the medication of the m	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with woke the child's inister Yes No					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CC authorization to self-carry/self-a PARENT/GUARDIAN SIGNATURE CELL PHONE # Child Care Responsibilities: 1.	o administer the med at least one dose of treatment for the ch re authorized period e staff and the autho DMAR 13A.15, 13A.1 administer medication	dication or to super the medication to r nild named above, i an authorized indi rized prescriber ind .6, 13A.17, and 13A on. School Age Chil DATE (mm/dd/yyy HOME PHONE #	rvise the child in my child without including the adrividual must pick dicated on this for A.18, the child call donly: OK to Servy) USE ONLY d. Expiration dat	adverse effects. To ministration of med to up the medication orm to communicat are program may revelf-Carry/Self-Adm VIDUALS AUTHORIZ DICATION WORK PHONE Set 1.	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be se in compliance with woke the child's inister Yes No					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CC authorization to self-carry/self-aauthorization to self-carry/self-aauthorizat	administer the med at least one dose of treatment for the ch re authorized period e staff and the autho DMAR 13A.15, 13A.1 administer medication	dication or to super the medication to rapid named above, in an authorized individed prescriber inc. 6, 13A.17, and 13A on. School Age Child DATE (mm/dd/yyy) HOME PHONE # CHILD CARE STAFF above was received as required by COI	rvise the child in my child without including the adrividual must pick dicated on this for A.18, the child call donly: OK to Servy) USE ONLY d. Expiration dat	adverse effects. To ministration of med to up the medication orm to communicatione program may revelled a communication or may	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with woke the child's inister Yes No ZED TO PICK UP					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CC authorization to self-carry/self-a PARENT/GUARDIAN SIGNATURE CELL PHONE # Child Care Responsibilities: 1. 2. 3. 4.	administer the mediat least one dose of treatment for the character authorized period estaff and the authorized period and the authorized period estaff and the authorized estaff and the authori	dication or to super the medication to repail of named above, if an authorized individed prescriber inc. 6, 13A.17, and 13A on. School Age Child DATE (mm/dd/yyy) HOME PHONE # CHILD CARE STAFF above was received as required by COI cy Form updated.	rvise the child in my child without including the adrividual must pick dicated on this for A.18, the child call donly: OK to Solvy) USE ONLY d. Expiration dat MAR.	and a communication of medication of medication of medication or medicat	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with voke the child's inister Yes No ZED TO PICK UP # Yes No					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CC authorization to self-carry/self-a PARENT/GUARDIAN SIGNATURE CELL PHONE # Child Care Responsibilities: 1. 2. 3. 4.	administer the medat least one dose of treatment for the charteness and the authorized period e staff and the authorized period and the authorized period e staff and the author	dication or to super the medication to repail of named above, if an authorized individed prescriber inc. 6, 13A.17, and 13A on. School Age Child DATE (mm/dd/yyy) HOME PHONE # CHILD CARE STAFF above was received as required by COI cy Form updated.	rvise the child in my child without including the adrividual must pick dicated on this for A.18, the child call donly: OK to Solvy) USE ONLY d. Expiration dat MAR.	and a communication of medication of medication of medication or medicat	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with voke the child's inister Yes No YED TO PICK UP # Yes No Yes No Yes No					
attest that I have administered a authority to consent to medical understand that at the end of the discarded. I authorize child care HIPAA. I understand that per CC authorization to self-carry/self-a PARENT/GUARDIAN SIGNATURE CELL PHONE # Child Care Responsibilities: 1. 2. 3. 4. 5.	administer the mediat least one dose of treatment for the character authorized period estaff and the authorized medication. Medication named Medication labeled OCC 1214 Emergen OCC 1215 Health In Individualized Treat Staff approved to a	dication or to super the medication to real the medication and authorized individed prescriber inc. 6, 13A.17, and 13A on. School Age Child DATE (mm/dd/yyy) HOME PHONE # CHILD CARE STAFF above was received as required by COI cy Form updated. Eventory updated. It went/Care Plan: Note that the ment/Care Plan: Note that the medication is the medication of the medicatio	rvise the child in my child without including the adrividual must pick dicated on this foliated on this foliated Only: OK to Soliated O	adverse effects. I deministration of medical communication of medication	as prescribed above. I certify that I have the legal lication at the facility. I ; otherwise, it will be e in compliance with woke the child's inister Yes No Yes No Yes No Yes No No Yes No No N/A					

Maryland State Department of Education Office of Child Care 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: Dosage: Time to Administer:			
Medication Name: Route:						
						DATE ADMINISTERED