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)

 Must pick up the medication at the end of authorized period, otherwise it will be discarded. 						
PRESC	RIBER'S AUTHORIZATIO	N				
Child's Name:	_Date of Birth:					
Condition for which medication is being administered:						
Medication Name:	Dose:	Route:				
Time/frequency of administration:		If PRN, frequency:				
If PRN, for what symptoms:		(PRN=as needed)				
Possible side effects &special Instructions:						
Medication shall be administered from:	to_					
Known Food or Drug: Allergies? Yes No If Yes, pleas Prescriber's Name/Title: Telephone: Address:		Month / Day / Year (not to exceed 1 year)				
Prescriber's Signature: (Original signature or signature stamp ON	Date:	This space may be used for the Prescriber's Address Stamp				
PARENT/ I/We request authorized child care provider/staff to administer administered at least one dose of the medication to my child w risk and consent to medical treatment for the child named abo and demonstrate medication administration procedure to the Parent/Guardian Signature:	without adverse effects. I/We ove, including the administration child care provider.	d by the above prescriber. I attest that I have certify that I/we have legal authority, understand the on of medication. I agree to review special instruction				
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SELF CARRY/SELF ADMINISTRATION	OF EMERGENCY MEDICATI may be authorized to self car	ON AUTHORIZATION/APPROVAL rry/self administer medication.)				
FACIL	LITY RECEIPT AND REVIEW					
Medication was received from: Special Heath Care Plan Received: ☐ YES ☐ NO		Date:				
Medication was received by:Signature of Person Rece	eiving Medication and Reviewin	g 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: Tim				Time(s) to administ	ime(s) to administer:		
DATE	TIME	DOSAGE	REACTIONS OF	BSERVED (IF ANY)	SIGNATURE		
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