MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE

Seizure/Convulsion/Epilepsy Disorder Medication Administration Authorization Form

Child's Name:_________________________Date of Birth:_______________

PARENT/GUARDIAN AUTHORIZATION		
I request the authorized child care staff to administer the medication as prescribed above. 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.		
PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received ☐ Yes ☐ No
2. Medication labeled as required by COMAR ☐ Yes ☐ No
3. OCC 1214 Emergency Card updated ☐ Yes ☐ No
4. OCC 1215 Health Inventory updated ☐ Yes ☐ No
5. Staff has received additional training to administer the medication ☐ Yes ☐ No ☐N/A
   If Yes: Trainer Name and Title_________________ Date__________
6. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No
7. Modified Diet/Exercise Plan ☐ Yes ☐ No ☐N/A
8. Individualized Plan: IEP/IFSP ☐ Yes ☐ No ☐N/A

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

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED	SIGNATURE