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. · An adult must bring the medication to the facility. Child's Picture 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 - Specify: to______Month / Day / Year (not to exceed 1 year) Prescriber's Name/Title: (Type or print) _____ FAX: _____ Telephone: ____ Address: ___ Prescriber's Signature: ___ (Original signature or signature stamp ONLY) This space may used for the Prescriber's Address Slamp **PARENT/GUARDIAN AUTHORIZATION** IWe request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. IWe certify that I/we have legal authority to consent to medical treatment for the child named above, including the administration of medicalion at the facility. I/We understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be Parent/Guardian Signature: ____ _____Work Phone #: ____ ____ Cell Phone #: _ SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL Self carry/self administration of emergency medication noted above may be authorized by the prescriber. Prescriber's authorization: ___ Signature Parental approval: ___ Signature **FACILITY RECEIPT AND REVIEW** Medication was received from: Special Heath Care Plan Received: YES NO

Signature of Person Receiving Medication and Reviewing the Form

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Medication was received by:

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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: Medication Name:				Date of Birth:	
				Dosage:	
Route:				Time(s) to administer:	
DATE	TIME DOSAGE		REACTIONS OBSERVED (IF ANY)		SIGNATURE
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