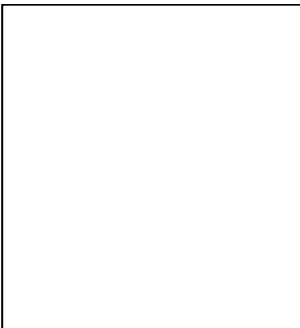


MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
MEDICATION ADMINISTRATION AUTHORIZATION FORM

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.
- Must pick up the medication at the end of authorized period, otherwise it will be discarded.



Child's Picture (Optional)

**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 & special Instructions: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_

Known Food or Drug: Allergies? Yes No If Yes, please explain \_\_\_\_\_  
Month / Day / Year Month / Day / Year (not to exceed 1 year)

Prescriber's Name/Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ (Type or print) FAX: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)



This space may be used for the Prescriber's Address Stamp

**PARENT/GUARDIAN AUTHORIZATION**

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**  
(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: \_\_\_\_\_  
Signature Date

Parental approval: \_\_\_\_\_  
Signature Date

**FACILITY RECEIPT AND REVIEW**

Medication was received from: \_\_\_\_\_ Date: \_\_\_\_\_

Special Health Care Plan Received:  YES  NO

Medication was received by: \_\_\_\_\_  
Signature of Person Receiving Medication and Reviewing the Form Date

