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)

PRESCRIBER'S AUTHORIZATION										
Child's Name:	Date of Birth: /									
Medication and Strength			Route/Method		& Frequency	Reason for Medication				
Medications shall be administered from:/ 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)							
TRESCRIBER S WANTE, THEE				riace stamp here (optional)						
TELEPHONE FAX										
TELETHONE										
ADDRESS										
PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)										
PARENT/GUARDIAN AUTHORIZATION										
	PARE	NT/GUARDIAN AU	THORIZATION	N						
I authorize the child care staff to					f-administratior	n as prescribed above. I				
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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:				
Medication Name:				Dosage:				
Route:				Time to Administer:				
DATE ADMINISTERED	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE			