

**Maryland State Department of Education  
Office of Child Care  
Medication Administration Authorization Form**

Place Child's  
Picture Here  
(optional)

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.**

**PRESCRIBER'S AUTHORIZATION**

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication and Strength	Dosage	Route/Method	Time & 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)
TELEPHONE	FAX
ADDRESS	

**PRESCRIBER'S SIGNATURE** (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

**PARENT/GUARDIAN AUTHORIZATION**

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. 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. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer**  Yes  No

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
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CELL PHONE #	HOME PHONE #	WORK PHONE #
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**CHILD CARE STAFF USE ONLY**

- |                              |   |
|------------------------------|---|
| Child Care Responsibilities: | 1. Medication named above was received. Expiration date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No                                    |
|                              | 2. Medication labeled as required by COMAR. <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|                              | 3. OCC 1214 Emergency Form updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A                                 |
|                              | 4. OCC 1215 Health Inventory updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A                               |
|                              | 5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
|                              | 6. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No                      |

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