

**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	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

CELL PHONE #

HOME PHONE #

WORK PHONE #

**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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**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.

<b>Child's Name:</b>				<b>Date of Birth:</b>	
<b>Medication Name:</b>				<b>Dosage:</b>	
<b>Route:</b>				<b>Time to Administer:</b>	
DATE ADMINISTERED	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE