

**MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure/Convulsion/Epilepsy Disorder
Medication Administration Authorization Form**

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**
Page 1 is to be completed by the authorized Health Care Provider.
FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

Place Child's
Picture Here
(Optional)

CHILD'S NAME: _____ Date of Birth: ____/____/____ Date of Plan: _____

Significant Medical/Health History: _____

Seizure Triggers or Warning Signs: _____

Allergies: _____

Seizure Care Information

Seizure Type	Length (duration)	Frequency	Description

Seizure Emergency Protocol: How to respond to a seizure (Check all that apply)

- ☐ First Aid – Stay. Safe. Side (refer to resource document “Seizure First Aid Guide”)
☐ Call 911 for transport to _____ ☐ Notify parent or emergency contact
☐ Notify Health Care Provider _____ ☐ Other _____
☐ Administer emergency medications as indicated below:

Medication Name & Strength	Dosage	Route/Method	Time & Frequency	Special Instructions

Care after seizure: Does the child need to leave the classroom after a seizure? ☐ Yes ☐ No

What type of help is needed? (describe) _____

When can the child return to care/resume regular activity? _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (original signature or signature stamp only)		DATE (mm/dd/yyyy)

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Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication as prescribed above. 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.

PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:	1. Medication named above was received. Expiration Date _____ 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Form updated 4. OCC 1215 Health Inventory updated 5. Staff has received additional training to administer the medication If Yes: Trainer Name and Title _____ 6. Staff approved to administer medication is available onsite, field trips 7. Modified Diet/Exercise Plan 8. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE