

**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: \_\_\_\_\_

<b>PARENT/GUARDIAN AUTHORIZATION</b>			
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			
<b>CHILD CARE STAFF USE ONLY</b>			
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	
	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5. Staff has received additional training to administer the medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	If Yes: Trainer Name and Title _____	Date _____	
	6. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	7. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	8. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE