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)

Child's Name:		PRESCRIBER'S AUTHORIZ	ZATION	
			Date of	Rirth. / /
Medication and Strength	h Dosage	Route/Method	Time & Frequency	Birth:/
			Time & Frequency	Reason for Medicatio
Medications shall be adv	minister 16			
If PRN, for what symptom	ma have fi	//to/_		
If PRN, for what symptor Possible side effects and	ns, now often and ho	ow long		
Known Food or Drug Alle	argies: Ves ON	16		
Known Food or Drug Alle	rigies: Li Yes LiNo	If yes, please explain:		
. o. ochool Age children (only: The child may se	elf-carry this medication: [□ Yes □No	
DESCRIPERIO MANAGE	The child may se	elf-administer this medica	ation: 🗆 Yes 🗆 No	
RESCRIBER'S NAME/TITLE				lere (Optional)
EL EDUONE			, and starrip ,	iere (Optional)
ELEPHONE	FA	X		
DDRESS				
RESCRIBER'S SIGNATURE (D	larant/a!			
PORTUGE (P	arent/guardian cannot	sign here) (original signature	e or signature stamp only) D	ATE (mm/dd/vvvv)
		OCANDIAN AUTHURIZ	ALIMAN	
attest that I have administra	tarr to administer the m	nedication or to supervise the	e child in self-administration	as prescribed above 1
authority to consent to me	dical treatment for the	of the medication to my child	without adverse effects. It	cortification and the second
		child named shave to the		ertily that I have the leg
understand that at the end	of the authorized period	ad an authorized in the	is the administration of med	ication at the facility. I
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OCC 1216 REVISED SEPTEMBER 2022 - all previous editions are obsolete