MARYLAND STATE DEPARTMENT OF EDUCATION OFFICE OF CHILD CARE

Seizure Medication Administration Authorization Form

Name of Child Care	Facility _					
This form authorizes emergency seizure care for				(Child's Name	□ M □ F	
while attending the child's physician and			-	ring child care hou	urs. This form must be completed by the	
Treating Physician				Phone#	# After Hours	
Significant Medica	l History: _					
				are Information		
Seizure Type	Leng	gth	Fi	equency	Description	
Seizure Triggers or W	Varning Sigi	ns:				
Seizure Emergency Pro Call 911 for transp	-				Notify parent or emergency contact	
☐ Notify treating ph						
☐ Administer emerg	ency medic	ations as		w:		
Emergency Dosage Medication		Time	Route/method Side Effects		Special Instructions	
Does child need to le the classroom.					S, describe process for returning the child to	
Special Consideration					etc.)	
Physician Signature:					Date:	
name of medication, be administered to m medication to my chi	directions for the directions of the directions of the direction of the directions of the direction of the dire	for medic lescribed adverse e child car	ation's admini and directed a ffects. I agree e provider. I u	stration, and date bove and attest th to review special i	container and labeled with the child's name, of the prescription. I request that medication nat I have administered at least one dose of the instruction and demonstrate the medication cand authorize for administration of	
Parent/Guardian Signature:					Date:	
OCC 1216A (8/20/15)						