## MARYLAND STATE DEPARTMENT OF EDUCATION OFFICE OF CHILD CARE DIMINISTRATION AUTHORIZATION FORM

	OFFICE OF CHILD CARE
<b>MEDICATION</b>	ADMINISTRATION AUTHORIZATION FORM

Child Care Program: \_\_\_

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact

<ul> <li>An adult must bring the medication to the face</li> </ul>		
PRESCR	RIBER'S AUTHORIZATI	ION
Child's Name:		Date of Birth:
Condition for which medication is being administered:		
Medication Name:	Dose:	Route:
ime/frequency of administration:		If PRN, frequency:
PRN, for what symptoms:		(PRN=as needed)
Possible side effects - Specify:		
Medication shall be administered from:Month / Da	1.4	to
		Month / Day / Year (not to exceed 1 year)
Prescriber's Name/Title:(Type or print)		
elephone:FAX:		
Address:		
Prescriber's Signature:	Date:	
	Date	
We request authorized child care provider/staff to admin	UARDIAN AUTHORIZA	prescribed by the above prescriber. I/We certify
PARENT/G  We request authorized child care provider/staff to admin hat I/we have legal authority to consent to medical treatm the facility. I/We understand that at the end of the auth liscarded.	UARDIAN AUTHORIZA ister the medication as p ent for the child named orized period, an adult n	ATION  orescribed by the above prescriber. I/We certify above, including the administration of medication nust pick up the medication, otherwise it will be
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