

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

Place Child's Picture Here (Optional)

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 to be completed by the Authorized Health Care Provider.

FOR SEIZURE/CONVULSION/EPILSEPSY MEDICATION ONLY - THIS FORM REPLACES OCC 1216

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:

Emergency Medication	Dosage	Route/method	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 _____

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 request the authorized 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	<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 Card 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 Plan: 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	REACTIONS OBSERVED (IF ANY)	SIGNATURE