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 _____ ❒ M ❒ F
(Child's Name) **(Date of Birth)**
while attending the above named child care facility during child care hours. This form must be completed by the child's physician and signed by both physician and parent.

Treating Physician _____ Phone#_____ # After Hours_____

Significant Medical History: _____

Seizure Care Information

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs: _____

Seizure Emergency Protocol (Check all that apply and clarify below)

❒ Call 911 for transport to _____ ❒ Notify parent or emergency contact

❒ Notify treating physician _____ ❒ Other_____

❒ Administer emergency medications as indicated below:

Emergency Medication	Dosage	Time	Route/method	Side Effects	Special Instructions

Does child need to leave the classroom after a seizure? ❒ **Yes** ❒ **No** If YES, describe process for returning the child to the classroom. _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____
_____

Physician Signature: _____ **Date:** _____

Parent Information & Authorization: Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects. I agree to review special instruction and demonstrate the medication administration procedure to the child care provider. I understand the risk and authorize for administration of emergency seizure medication to my child.

Parent/Guardian Signature: _____ **Date:** _____