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) ____________ (Date of Birth) M ☐ F ☐

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

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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</table>

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:

<table>
<thead>
<tr>
<th>Emergency Medication</th>
<th>Dosage</th>
<th>Time</th>
<th>Route/method</th>
<th>Side Effects</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
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</table>

Does child need to leave the classroom after a seizure? ☐ Yes ☐ No ☐ Other ______________________

If YES, describe process for returning the child to the classroom. ______________________

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

Scientific 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: ____________

OCC 1216A (8/20/15)