MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM
Waldorf School of Baltimore

Child's Picture (Optional)

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.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

PRESCRIBER'S AUTHORIZATION

Child's Name:_____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name:_____ Dose:_____ Route: _____

Time/frequency of administration:_____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions:_____

Medication shall be administered from:_____ to _____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain_____

Prescriber's Name/Title: _____
(Type or print)

Telephone:_____ FAX: _____

Address: _____

Prescriber's Signature:_____ Date:_____
(Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature:_____ Date: _____

Home Phone #:_____ Cell Phone #:_____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature — Date

Parental approval: _____
Signature — Date

FACILITY RECEIPT AND REVIEW

Medication was received from:_____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date

PRN (AS NEEDED) MEDICATION RECORDING FLOW SHEET

STUDENT NAME: _____ GRADE: _____ SCHOOL: _____ YEAR: _____

PRN MEDICATIONS: _____
(INCLUDE NAME, DOSE, ROUTE AND FREQUENCY)

REASON FOR MEDICATION: _____

DATE	TIME	INITIALS	PRESENTING SYMPTOMS	ACTION TAKEN	RN NOTIFIED	OUTCOME

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