MARYLAND STATE DEPARTMENT OF EDUCATION OFFICE OF CHILD CARE

Seizure Medication Administration Authorization Form

This form authorizes emergency seizure care for	This form authorize	ac amaraana	, coizuro co	are for			
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. Phone#	This form authorizes emergency seizure care for				(Child's Name)	(Date of Birth)	טועו טו
Seizure Type	while attending the	above nam	ed child ca	re facility during	child care hour		
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	Treating Physician				hone#	# After Hours	
Seizure Type Length Frequency Description	Significant Medica	al History: _					
Seizure Triggers or Warning Signs: Seizure Emergency Protocol (Check all that apply and clarify below) Call 911 for transport to				Seizure Care	e Informatio	n	
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Call 911 for transport to Notify parent or emergency contact Notify treating physician Other Other Administer emergency medications as indicated below: Emergency Dosage Time Route/method Side Effects Special Instructions Medication No If YES, describe process for returning the child to the classroom Special Considerations and Precautions (regarding activities, sports, trips, etc.) Physician Signature: Date: 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 are administered to my child as described and directed above and attest that I have administred 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.	Seizure Triggers or	Warning Sigi	ns:				
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Medication Does child need to leave the classroom after a seizure? 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 the mergency seizure medication to my child.							
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Physician Signature:	he classroom						
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Parent/Guardian Signature: Date: Date:	Scriey Scizure	carcation t	o, cilia.				
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	OCC 1216A (8/20/15)						