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

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

OCC 1216A  (8/20/15)