MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

# MEDICATION ORDER FORM

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions. Prior written permission from the child's parent is a requirement. If possible, arrange the time of dosage so the child receives the medication at home. Fill out a separate form for each prescription or non-prescription drug.

**PRESCRIPTION MEDICATION:** Prescription medications must be in a container labeled by the pharmacy or physician with the child's name and expiration date. The child may receive medication only according to the written instructions of the health practitioner or the instructions on the medication label, as shown below.

**NON-PRESCRIPTON MEDICATION:** A child may receive only one dose per illness, expect acetaminophen (Tylenol) and topical medication. A licensed health practitioner must approve the medication and dosage for the child to receive more than one dose.

Name of Child:_____

This medication is begin given for the following condition(s):_____

| MEDICATION | DOSAGE | WHEN TO GIVE | DATES TO ADMINISTER | |
|---|---|---|---|---|
| | | | START | STOP |
| | | | | |
| ADDITIONAL INSTRUCTIONS (including instructions not given on the prescription): | | | | |
| Note any side effects of this medication: | | | | |
| Note any reasons or conditions when this medication should be stopped or not given: | | | | |

I/We authorize_____ to administer the above named medication to my/our child.
Name of Child Care Provider or Facility

Signature of Parent:_____ Date:_____

| COMPLETE ONLY IF MORE THAN ONE DOSE OF NON-PRESCRIPTION MEDICATION IS TO BE GIVEN | |
|---|---|
| Instructions for more than one dose of a <u>non-prescription medication:</u> | |
| Note any side effects of this medication: | |
| Note any reasons or conditions when this medication should be stopped or not given: | |
| Signature of Health Practitioner: | Date: |
| Stamp, Print or Type Name of Health Practitioner | Phone Number: |
| If the above section is not signed by the health practitioner, the health practitioner/designee must give oral permission to the provider directly, and the provider must complete the following: | |
| Name of Practitioner or designee giving approval: | |
| Signature of person receiving approval from health practitioner: | Date:<br>Time: |

## MEDICATION ADMINISTERED

The provider or facility shall maintain a record of the administration of medication.
Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

| Child's Name: | Date to stop giving medication: |
|---|---|
| Medication: | |

| DATE | TIME | DOSAGE | REACTIONS OBSERVED (IF ANY) | SIGNATURE |
|---|---|---|---|---|
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