

MEDICATION ADMINISTRATION FORM

Department of Health & Mental Hygiene (DHMH)
 Center for Healthy Homes and Community Services (CHHCS)
 6 St. Paul Street, Suite 1301
 Baltimore, Maryland 21202-1608
 (410) 767-8417 FAX (410) 333-8926
 Toll Free 1-877-4MD-DHMH ext. 8417

I. FACILITY RECEIPT AND REVIEW			
MEDICATION RECEIVED FROM			DATE
PLAN OF ACTION RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		HEALTH SUPERVISOR NOTIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO	
MEDICATION RECEIVED BY	PERSON'S SIGNATURE	DATE	

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:				Date of Birth:	
Medication Name:				Dosage:	
Route:				Time(s) to Administer:	
DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	ADMINISTERED OR SUPERVISED BY SIGNATURE