AUTHORIZATION TO ADMINISTER MEDICATION

Check one: ☐ Prescription Medication ☐ Non-Prescription Medication

PARENTS/GUARDIANS/CAREGIVERS STATEMENT

I do hereby authorize the designated staff of Paladin to administer the medication indicated below for ____
PRINT NAME.

I understand that I will be responsible for supplying this medication to Paladin and that it is to be sent in the original prescription bottle.

MEDICATION:________________________DOSAGE:______________________

Preferred time(s) of administering:____

Purpose of medication:____

Please note: The physician's statement and the Parent's authorization are valid only for one year from the date they are signed for prescription medications. Unless the authorization and statement are renewed, the medication cannot be given to the client.

Any change in medication and/or dosages will require an additional physician's statement and authorization form before the medication can be given to the client.

Can this medication be dispensed ½ hour before or ½ hour after requested time of dispensing?

YES__________ NO___________

Can this medication be given as needed? YES____________ NO_____________

How would you prefer to send this medication: ___Daily ___Weekly ___Monthly

_____________________________	____
Date	Parent/Guardian/Caregiver
_____________________________	____
Telephone	Address

Emergency Phone_________________________________

S Drive: Consumer Related/Intake File: Meds Admin Authorization
Revised: 1-4-2016

PHYSICIAN'S STATEMENT

I HAVE PRESCRIBED THE MEDICATION INDICATED BELOW FOR________________________, AND DO HEREBY AUTHORIZE THE DESIGNED STAFF OF PALADIN TO ADMINISTER THE MEDICATION AS INDICATED.

MEDICATION:____

DOSAGE/TIMES:____

PURPOSE:____

____

IF THE PATIENT ACCIDENTLY MISSES A DOSAGE, WHAT MAKEUP PROCEDURES, IF ANY, SHOULD BE IMPLEMENTED?

CAN THIS MEDICATION BE ADMINISTERED AS NEEDED?

____
DATE

____
PHYSICIAN'S PRINTED NAME SIGNATURE