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_____

Director Signature _____ Date _____

Program Manager: Attach this form to the MAR along with a list of side effects and drug interactions for the medication. Do not administer this medication without Director approval.

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

PHARMACY

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____

TELEPHONE: _____

NAME OF PHARMACIST: _____

*Medications may be administered up to 30 minutes before or 30 minutes after stated time, per Paladin policy. If this medication must be given at the exact time, please provide a written explanation for the necessity and submit it with this form.