

Medication Administration and Emergency Medical Authorization

Person name: _____

Program name: _____

Check the applicable boxes and sign and date this authorization form.

Medication Administration Authorization

- I authorize staff trained by the program to provide medication setup and/or medication administration (prescription medications, including psychotropic medications, and over-the-counter medications) or treatments to me ordered for me by a health care professional.

Medication setup means:

- Program staff arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration.

Medication administration means:

- Program staff checking the person's medication record;
- Program staff preparing the medication as necessary;
- Program staff administering medications or treatment to the person;
- Program staff documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and
- Program staff reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

This program is required to complete the following when assisting you in administering medications and/or medication setup or treatments to you:

(Insert specific instructions)

- 1.
- 2.

- I authorize staff trained by the program to provide medication assistance so I am able to self-administer my medications or treatments.

Medication assistance means:

- Program staff opening the container of previously set-up medications, emptying the container into my hand, or opening and giving the medication in the original container to me;
- Program staff bringing me liquids or food to accompany my medications; or
- Program staff providing me reminders to take my regularly scheduled medications, treatments or exercise.

This program is required to complete the following when completing medication assistance for you:

(Insert specific instructions)

- 1.
- 2.

- I authorize administration of injectable medications according to my prescriber's order and written instructions (check the applicable option):
 ___ a registered nurse or licensed practical nurse will administer the injection;
 ___ a supervising registered nurse with a physician's order has delegated the administration of injectable medication to an unlicensed staff member and has provided the necessary training; or
 ___ there is an agreement signed by the program, the prescriber, and the person or the person's legal representative specifying what injections that may be given. The prescriber retains responsibility for the program giving the injections. A copy of this agreement will be placed in the person's record.
- What injection may be given:
 - When may the injection be given:
 - How may the injection be given:

Only licensed health professionals are allowed to administer psychotropic medications by injection.

- I refuse to authorize staff trained by the program to administer medications (prescription and over-the-counter) or treatments to me ordered for me by a health care professional.
- If I refuse to provide authorization I understand that the program is required to report my refusal to the person who prescribed the medication or treatment as soon as possible.
 - If I refuse to provide authorization for use of psychotropic medications I understand that the program will notify the prescriber and must also follow any directives or orders given by the health care professional who prescribed the psychotropic medication; however the program will not administer the medication. I also understand that the program must seek a court order to override my refusal. Refusal to authorize the use of a specific psychotropic medication is not grounds for service termination. Refusal does not constitute an emergency and the program is not allowed to manually restrain me if I do refuse.

Medical Emergency Authorization

- I authorize the program to act in a medical emergency when the person or the person's legal representative cannot be reached or is delayed in arriving.

I may revoke or revise this authorization at any time by making a written request.

Name	Signature	Title	Date
		Person	
		Legal Representative	
		Program **	
		Prescriber **	

** Program and prescriber signatures only required for subcutaneous injection authorization.