Medication permissions

Resident name: DOB:

License Holder name:

Medical provider permissions (excludes injectable medication)

The resident listed above may self-administer all prescribed and authorized OTC medications and supplements (please attach sheet with prescribed and authorized supplements).

The resident listed above with supervision may self-administer all prescribed and authorized OTC medications and supplements (please attach sheet with prescribed and authorized supplements). The license holder, or trained caregiver, may administer medications if the resident desires.

The resident listed above needs assistance administering all prescribed and authorized OTC medications and supplements (please attach sheet with prescribed and authorized supplements). The license holder, or trained caregiver, may administer medications if the resident desires.

The license holder, and trained caregivers, should follow an alternate medication administration procedure (attach directions – i.e. comments on a visit summary if a resident is capable of self-administering only certain medications).

The license holder, and trained caregivers, listed above have permission to administer all prescribed and authorized OTC medications and supplements (please attach sheet with prescribed and authorized supplements).

Signature Date

Medical Provider Printed Name/Title

Resident/legal representative permissions

By signing below, I understand that the AFC license holder and/or trained caregivers may administer my medication and supplements to me as indicated above by my medical provider. I understand the level of administration or self-administration my provider has approved.

Resident Signature Date

Legal Representative Signature Date

Program Name: **Resident Name:** **DOB:**

Month: **Year:** **Allergies:** **Notes:**

Medication Information	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Name:																																
Dose: Route:																																
Frequency:																																
Prescriber:																																
Notes:																																
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Notes:																																

Signature	Initials	Signature	Initials
Signature	Initials	Signature	Initials

Notify prescriber of missed doses or refusals. Notify licensor if prescriber deems the missed dose as life threatening.

Medication Count and Disposal **Resident Name:**

Month: **Year:**

Medication Information	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Name: Dose: Quantity: Reason disposed of:																															
Name: Dose: Quantity: Reason disposed of:																															
Name: Dose: Quantity: Reason disposed of:																															
Name: Dose: Quantity: Reason disposed of:																															
Name: Dose: Quantity: Reason disposed of:																															
Name: Dose: Quantity: Reason disposed of:																															

Signature	Initials	Signature	Initials
Signature	Initials	Signature	Initials

Indicate "NA" in the reason disposed of if the medications were only counted.

Authorization to Give Injectable Medication

THE PROVIDER shall not give injectable medication unless:

A. The provider is a Registered Nurse or Licensed Practical Nurse with a current Minnesota License, is authorized to do so in writing by the resident's physician and is covered by professional liability insurance, OR:

B. There is an agreement signed by the provider, the resident's physician and the resident (or legal representative) specifying what injections may be given, when, how, and that the physician shall retain responsibility for the provider giving injections. A copy of the agreement must be placed in the resident's personal record.

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______________________________ Resident's Name

______________________________ Date of Birth

______________________________ Name of Foster Care Provider

______________________________ Date of Resident's Admission

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A. *The provider is a Registered Nurse or Licensed Practical Nurse licensed in Minnesota.*

______________________________ Signature of Provider

______________________________ License Title and Number

______________________________ Professional Liability Insurance Policy

______________________________ Date

______________________________ Signature of Resident=s Physician

______________________________ Date

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B. *There is a signed agreement by the provider, resident' s physician, and the resident or legal representative.* Please list the injectable medications that may be given by the foster care provider and staff, including what, when and how the medication(s) is to be given:

Medication	*Dose*	*Frequency/Route*

______________________________ Resident or Legal Representative

______________________________ Date

______________________________ Authorization and Signature of Physician

______________________________ Date

______________________________ Signature of Foster Care Provider

______________________________ Date