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| To: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Care Provider |
| From:        |
| Date:        |
| Re: **AUTHORIZATION TO DISPENSE MEDICATIONS** |
| Patient Name:        |
| Patient DOB:       |

The above-named patient is currently residing in, or moving into, an Adult Family Home. There must be a written order from the physician allowing the Adult Family Home Provider to administer or assist a resident in administering any prescription and/or over the counter medication.

Please check one:

[ ]  Patient is able to **self-administer** medications.

[ ]  Patient requires **reminders** to take medications.

[ ]  Patient requires **supervision** in taking medications.

(“Supervision” means that the patient is responsible to remove the medication from the medication container. However, the patient requires observation in taking the proper dose at the proper time.)

[ ]  Patient requires **medication administration** by the adult family care provider.

(“Administration” means that the foster care sponsor is responsible to remove the proper dosage from the medicine container and give it to the patient. This also involves any type of set-up of medications in which the adult family care provider is responsible to remove the proper dosage from the container.) PLEASE LIST ALL MEDS AUTHORIZED TO BE ADMINISTERED OR ATTACH A COPY OF THE MOST RECENT MED LIST.

\*\*For a list of current medications see attached MAR or Physician’s Order\*\*

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Health Care Provider Signature Date