Stark County Board of Developmental Disabilities

Administration of Medication

MED 2A

Individual's Name:_____ School/Workshop_____

Individual's Address:_____

Reason for Medication:_____

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TO BE COMPLETED BY PHYSICIAN

Medication	Dosage/Route	Time to be Administered	Adverse Reactions to be Reported	Date Medication Begins/Ceases
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____
_____	_____	_____	_____	_____/_____

Special instructions if any:_____

_____

DURING FIELD TRIPS, MEDICATION **MAY/MAY NOT** BE **DELAYED/OMITTED** = PLEASE CIRCLE.

Authorization is given for physical and/or occupational therapy evaluation. ☐ Yes ☐ No

_____/_____ _____

Physician's Name (**PRINT**) Signature (**NO STAMPS**) Date Office Phone Number

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TO BE COMPLETED BY PARENT/GUARDIAN

I HEREBY GIVE THE PERSONNEL OF THE Stark County Board of DD permission to administer the above prescribed medication to me/my son/daughter.

_____ _____ _____ _____

Individual's Signature Date Parent/Guardian Signature Date

MEDICATION GUIDELINES

1. This form must be completed and the original returned to school/workshop nurse for any medication to be administered during program day by school/workshop personnel. This includes prescription/non-prescription medication, oral or topical. More than one medication may be listed on one form.
2. This form must be signed by the physician and legal guardian.
3. If the medication is changed, a new form is required. Notify the school/workshop nurse when medication is discontinued.
4. All medications (nurse or self administered) must be in a pharmacy labeled container. The label must include the individual's first and last name, name and strength of medication, amount to be taken, and time to be taken.
5. No more than one week's supply of a medication should be sent to the school /workshop at a time – daily dose only for individual's self administering.
6. Individual's self administering medication should have the self medication assessment form completed and on file with the school/ workshop nurse.