HCESC Thrive Day Habilitation Medical Form

Authorization for RX/OTC Medication Administration

(to be completed by physician)

This form is to be completed for all medications,(including herbal/natural supplements and vitamins), other than asthma medications and epinephrine.

- Original copy of this form is required by the NJ State law.
- State law requires that medication be renewed each year. Year:_____
- **Only one medication per form.**

Name_____ DOB _____Date _____

Diagnosis _____

Allergies_____

Medication _____

Dosage_____ Time/Frequency _____Route_____

Duration of Treatment (if applicable) _____

Maximum amount to be given during a 24-hour period: _____

Possible Side Effects _____

MEDICATION ORDER FOR TRIP DAYS (Please note most trips are full day)

___ Dose may be omitted ___ Dose to be given on return to THRIVE_____.

___ Other (please specify):_____

MEDICATION ORDER FOR EARLY DISMISSAL

___ Omit afternoon dose ___ Maintain original order

***In the event that the consumer is not given their morning dose at home, the nurse may give the medication listed above with client / parental permission*. AM DOSE: _____**

_____ _____ _____

Provider's Signature **Office Stamp** **Date**

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Client / Parent / Guardian Consent for Giving Medication

(To be submitted with the Authorization for RX/OTC Medication Administration

I request and give my consent for the Nurse or other individuals authorized to administer medication to clients. to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the Nurse in the original pharmacy container labeled with the client's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members and for the safety and welfare of_____

I give permission for the nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

I request that _____ be assisted in taking the medication described below at THRIVE by the Nurse or other individuals authorized to administer medication to clients. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the nurse and others may require their presence at another location at the time that the medication is needed. I understand that the Hunterdon County Educational Services Commission, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the Hunterdon County Educational Services Commission, its agents and employees against any claims arising out of administration or lack of administration of this medication.

Applicant Signature: _____

Caregiver/ Guardian Name (please print) : _____

Caregiver/ Guardian Signature: _____

Today's Date: _____