Skill Building Medication Administration Consent Form

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_CASE NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEGAL

REPRESENTATIVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMERGENCY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOCTOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOCTOR’S PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned give my consent for trained Sanilac CMH staff to administer prescribed medications to the above named individual. I understand that only these trained staff will administer medication. I further understand that I am responsible for supplying an adequate amount of medication during the monthly period and for prn medications as needed through the year.

I am also responsible for giving Program personnel the doctor’s written instructions regarding administration times & dosages to include all medications, prescriptions & over-the-counter drugs. All medications provided will be in their original containers. **I will notify the Medication Coordinator of changes or discontinuation of the medication(s).**

**NOTE: ONLY PRESCRIBED DRUGS, PRESCRIPTION AND OVER-THE-COUNTER DRUGS WITH A DOCTOR’S WRITTEN INSTRUCTIONS, WILL BE ADMINISTERED.**

### Medication to be Administered

**Prescription Drugs**: Must be in a container with a pharmacy label and must correspond with physician’s order.

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Name of medication Purpose

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Name of medication Purpose

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Name of medication Purpose

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**Over-the-Counter Drugs**:Must be in the original container with pharmacy label and must correspond with physician’s order. (Aspirin, cough syrup, etc.)

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Name of medication Purpose

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Name of medication Purpose

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Name of medication Purpose

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Print Full Name of Individual/Parent/Guardian Individual/Parent/Guardian Signature Date

Verbal Consent from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Individual/Parent/Guardian) (Date received)

Verbal Consent Witnessed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Witness) (Name of Witness)

**\* RETURN TO MEDICATION COORDINATOR: SCCMHA, 227 E. SANILAC AVE., SANDUSKY MI 48471**