PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS AND / OR TREATMENTS

Trumbull County Board of Developmental Disabilities – Fairhaven School Program
420 Lincoln Way, Niles, Ohio 44446

School 330-652-5811 FAX 330-652-5864

It is recommended that whenever possible, medications and / or treatments be administered at home. When necessary medications and treatments shall be administered during program hours according to Board Policy and procedures **once signed permission has been submitted from the Physician and from the parent / guardian / provider:**

Signed permission is limited to one – which must be renewed.

Name: _____

Address: _____

CITY STATE ZIP PHONE

Known **ALLERGIES: (List all)** _____

As parent / guardian / provider of the above-named consumer, I hereby give my permission for administration of the following:
[ ] **Prescription medication(s)** [ ] **Non-prescription medication(s)** [ ] **Treatment(s)** as ordered below by the attending physician. I understand that medications and treatments provided at the Fairhaven Program shall be guided by the rules and guidelines of the Board Policies and Procedures.

_____ _____
Parent / Guardian / Provider Date

The above named person requires the following during Fairhaven Program hours.

PRESCRIPTION MEDICATION(S):

DRUG	DOSE	ROUTE	EXACT TIMES TO BE GIVEN	LENGTH OF RX Beginning/End Date	REPORTABLE SIDE EFFECTS

NON-PRESCRIPTION MEDICATION(S):

DRUG	REASON FOR RX	DOSE	FREQUENCY	ROUTE	REPORTABLE SIDE EFFECTS

TREATMENT(S): Use separate order forms for gastrostomy feedings

TYPE OF TREATMENT	REASON	EXACT TIMES TO BE GIVEN	SPECIAL INSTRUCTIONS For handling-giving or applying medication	REPORTABLE SIDE EFFECTS

NAME OF PHYSICIAN SIGNATURE OF PHYSICIAN DATE

Address (of physician) City State Zip Phone Number