Phone: 740-992-6681
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1310 Carleton Street
Svracuse, Ohio 45779

MEIGS COUNTY BOARD OF **DEVELOP**MENTAL DIS**ABILITIES**
PERMISSION TO ADMINISTER MEDICATION FORM:

PARTICIPANT SECTION TO FILL OUT:

Name**:** _____ DOB: _____

Address: _____ Phone: _____

_____

Please check all that apply:

1. ___ The above currently does not take any medications.
2. ___ The above is currently not on a special diet (pureed, soft mechanical, choking precautions)
3. ___ The above currently takes all medications at home only.
4. ___ The above will need to take medication while at school/workshop between the hours of 9:00 am & 2:30pm.
5. ___ The above has a special diet (pureed, soft mechanical, choking precautions)

If both 1 and 2 are checked a primary health care provider order is not needed. Please sign below and send back to the school/workshop. No further action is required. * See instructions below if 4 or 5 is checked.

Individual/Parent/Guardian signature: _____ Date: _____

*If 4 or 5 is checked a primary health care provider (PCP) order is needed. Please have PCP fill out the needed information and return this form to the school/workshop. You will need to sign at the bottom of this form. Please call the school nurse before sending in the medications to be administered.

MEDICATION/DIET/TASK ORDER FOR PRIMARY HEALTH CARE PROVIDER TO FILL OUT:

Medication Allergy: _____
Food Allergy: _____
Insect Allergy: _____
(Please provide a medication order, if an Epi-Pen is required for insect allergy)

Medication/Task: Dosage/Route: Amount: Time: Diagnosis Side Effects/Instructions:

_____

_____

_____

The student/adult participant will be responsible for packing their lunch if a special diet is indicated with the exception of pureed and soft diets.

___ **Special Diet Order:** _____

MEDICATION OR DIET START DATE: _____
MEDICATION OR DIET STOP DATE: _____

Medication and Diet orders are in effect for one year from the start date, unless noted otherwise on the stop date. If a shorter time period is ordered for some medications but not for all medications please indicate this in the instruction column of the medication order.
This Document will serve as the official order for the registered or licensed nurse and trained delegated Meigs County Board of Developmental Disabilities employee to administer the prescribed medication or treatment.

Primary Health Care Providers Signature: _____ DATE: _____

Primary Health Care Providers printed name: _____ PHONE: _____

I AGREE TO DELIVER ALL MEDICATION IN THE ORIGINAL MEDICATION BOTTLE WITH NO MORE THAN A TWO WEEK SUPPLY. ALL MEDICATIONS WILL NEED TO BE HANDED TO THE DRIVER OR STAFF. NO STUDENTS/ADULTS ARE TO CARRY MEDICATIONS.

I AGREE TO PROVIDE WRITTEN NOTIFICATION BY A PRIMARY HEALTH CARE PROVIDER IF THE MEDICATION, THE DOSAGE OR THE PROCEDURE HAS CHANGED OR IS DISCONTINUED.

INDIVIDUAL/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____