



RELEASE FOR ADMINISTERING MEDICATION

The person served and/or the guardian **must sign** the appropriate section of this form.

Release for medication administration for _____
(Name of Person Served)

A. Complete and sign if the person served takes medication during program hours but is not capable of self-administering medications.

_____ hereby authorizes and requests Chimes, its employees, agents, and/or representatives to administer, when necessary, any prescribed medication(s) to the person named above and releases the Agency, its employees, agents, and/or representatives of responsibility for any adverse reaction which may result from the administration of said prescribed medication(s).

Signature of Person Served/Date

Witness/Date

Signature of Guardian (if applicable)/Date

Witness/Date

B. Complete and sign if the person served takes medication, BUT NOT DURING PROGRAM HOURS.

This is to certify that _____ does not take any medication during the hours when he/she is participating in the Chimes day program.

Signature of Person Served/Date

Witness/Date

Signature of Guardian (if applicable)/Date

Witness/Date

C. Complete and sign if the person served is self-medicating based upon approval by primary care practitioner and Chimes/Intervals.

This is to certify that I, _____, does take medications and that I assume full responsibility for taking these medications independently, in accordance with my physician's orders and instructions.

Person's Signature/Date

Witness/Date

D. Complete and sign if the person served DOES NOT TAKE ANY MEDICATION.

This is to certify that _____ does not take prescribed medications of any kind.

Signature of Person Served/Date

Witness/Date