EFM RESPITE CARE
AUTHORIZATION FOR MEDICATION ADMINISTRATION

Name:	Date of Birth:	Home Address:	Home Phone Number:	Last Updated:

Allergies to Medications:	

CURRENT MEDICATION REGIMENT

MEDICATION	PURPOSE	DOSAGE	FREQUENCY/TIME	DURATION	POSSIBLE SIDE EFFECTS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

AUTHORIZATION FOR MEDICATION ADMINISTRATION

I hereby authorize, my authorized respite care provider(s) to administer the above medications, to my child, _____. I further agree to indemnify and hold harmless this provider, his/her agents, and servants against all claims of any acts performed under this authority.

_____	_____	_____
Parent/Guardian Name	**Parent/Guardian Signature**	**Date**

Medication in EFM Respite Care:

1. Requires parent/guardian to complete and sign this *Authorization for Medication Administration*; form shall be kept in the child's file with all supportive documentation. (Please sign, date, and write N/A if not applicable).
2. Medication must be in original, child-proof container and labeled with child's name.
3. Requires a written plan to record the administration of all medications and to inform the child's parent/guardian daily when medications have been given.

Prescription Medications:

1. Medication is administered with the pharmacy label directions as prescribed by the child's health care provider.
2. The instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.