Medication Assistance Authorization

I, ____am authorizing

____
(Agency)

to provide medication assistance as designated by the agreed Service Plan. Medication assistance includes, but is not limited to, any of the following:

(a) Loosening the cap on a pill bottle for oral medication;
(b) Opening a pill reminder box if the box is filled by the service recipient or authorized representative or licensed medical personnel practicing within the scope of their license;
(c) Placing medication within reach of the service recipient;
(d) Holding a service recipient's hand steady to help them with drinking liquid medication;
(e) Guiding the service recipient's hand when the individual is applying eye/ear/nose drops and wiping the excess liquid;
(f) Helping with a nasal cannula or mask for oxygen, plugging the machine in and turning it on;
(g) Applying non-prescription creams and lotions purchased over-the-counter to external parts of the body.

If medication reminders are requested, the following is a current list of medication to be observed:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

I understand that I must notify the agency with any changes in the medication.

____ ____
Service Recipient or Authorized Representative Date

____ ____
Agency Representative Date