MONTGOMERY COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

MEDICATION AUTHORIZATION

Starting Date: _____

FOR YOUR DOCTOR TO FILL IN:

Please fill in only those medications that are to be given under Board of MR/DD supervision.

Name: _____ _____ DOB: _____ _____

1. _____
   Medication Dosage Route Time/Interval

2. _____
   Medication Dosage Route Time/Interval

Termination Date: _____

Reactions to medications that should be reported. Special Instructions:

_____

_____

_____

_____

Physician Signature: _____
Date

Physician Name: _____

Address: _____
Street City State/Zip

Phone #: _____ Emergency Phone #: _____

Please Note:

1. If any changes in medication notify nurse
2. Please order mediation to be given **other than during program hours if possible.**

Program: _____

Building: _____

MONTGOMERY COUNTY BOARD OF MR/DD

I, the undersigned request the giving/applying of medication for,

_____

Full Name (Enrollee) Date of Birth

_____

Address

_____

Telephone Number Emergency Telephone Number

in accordance with the instructions of our physician (see other side of this paper).

Further, I will be responsible for delivery of the medications in an original container and supplies to the facility and will notify the program immediately, if we change physicians or medications or terminate the use of medication for any reason.

_____

Signature of Parent/Guardian/Person Having Care or Charge Date

_____

Signature of Enrollee (if not a minor) Date