APPROVAL TO SELF-ADMINISTER MEDICATION

In accordance with IDAPA 16.03.19.401, before allowing a resident to self-administer his or her medications, the CFH provider must obtain approval from the resident's health care professional.

RESIDENT

The resident is the adult receiving care in the provider's certified family home.

Full Legal Name:	Date of Birth:
Diagnoses:	

EVALUATION

This evaluation is based on the resident's current condition assessed today. If his or her condition should change, the certified family home provider must have this assessment reevaluated by the health care professional. The health care professional has evaluated the resident in the following areas:

The resident understands the purpose of each medication.	Yes ☐	No ☐
The resident is oriented to time and place and knows the appropriate dosage and times to take the medication.	Yes ☐	No ☐
The resident understands the expected effects, adverse reactions, or side effects, and knows what actions to take in case of an emergency.	Yes ☐	No ☐
The resident is able to take the medication without assistance or reminders.	Yes ☐	No ☐

HEALTH CARE PROFESSIONAL APPROVAL

The health care professional's signature below indicates the resident listed on this form is approved to self-administer medications. All elements listed in the evaluation must be assessed as "Yes" before the health care professional may give approval.

Printed Name:	Business Phone: ( )
Practice Name:	
_____ HEALTH CARE PROFESSIONAL'S SIGNATURE	_____ DATE

CERTIFIED FAMILY HOME PROVIDER

The provider is the adult responsible for maintaining the certified family home and providing care to residents. Please return this completed form as follows:

Provider Name:		
Telephone Number: ( )	Email:	
Mailing Address:		
Mailing City:	Mailing State:	Mailing ZIP: