R.O.O.C. Inc.

MEDICATION CONTROL FORM

Name: _____ Program: _____

Staff Person Administering Medication: _____ Position: _____

To be completed by Physician

Prescription(s):
Name of Medication: _____
Dosage: _____ Frequency: _____ Time of Administration: _____

Name of Medication: _____
Dosage: _____ Frequency: _____ Time of Administration: _____

Name of Medication: _____
Dosage: _____ Frequency: _____ Time of Administration: _____

Name of Medication: _____
Dosage: _____ Frequency: _____ Time of Administration: _____

Comments Regarding Prescription: (Hazards, Directions and Purpose of Medication)_____
_____
_____
_____
_____

☐ This individual is funded by Northern Lakes Community Mental Health. All applicable medication information including guardian authorization is obtained via the responsible mental health agency. R.O.O.C. Inc. receives a copy of the physicians order if medication is prescribed and administered during R.O.O.C. Inc. hours of operations. Refer to R.O.O.C. Inc. daily medication log for current listing of medications.

☐ This consumer is a CEC student. All medication related documentation and administration is performed by the classroom teacher.

I hereby request that _____ be administered the prescribed medication at R.O.O.C. Inc. by the personnel listed above. I understand that the medication will be administered exactly as per the directions of my physician. I will notify R.O.O.C. Inc. of changes or discontinuation of this medication.

Signed: _____
(Individual, Parent or Legal Guardian)

Address: _____

Date: _____ Phone: _____