445 A Willard Ave
Newington. CT 06111

MEDICATION POLICY AND CONSENT FORM

RESPONSIBILITIES OF CLIENT OR RESPONSIBLE PARTY

I Physician's order

(a) Prior to admission, Family Adult Day Care must have a signed written order from the physician with the participant's full name, medication name, dosage, frequency, instructions for all medication.

(b) The order is to include the same information for all PRN medications.

(c) **A physician's order is required before medications can be administered at the Center.**

II Changes in Medication

(a) Any changes in medication including increases, or decreases, in all ongoing medications or new medications, require immediate notification to the nurse, via a signed physician's order.

III Labeling of Medications

(a) All medications taken at Family Adult Day Care must be in the labeled container issued by a licensed pharmacist. The label shall include a date and directions.

(b) Labels must be legible – worn, torn, or dirty labels must be replaced by pharmacist.

IV Delivery of Medication to Family Adult Day Care

(a) Whenever possible and appropriate, all medications shall be delivered to Family Adult Day Care by a pharmacy, a participant, or a participant's responsible person.

When the above cannot be carried out, a Family Adult Day Care nurse may give the responsible party permission to deliver the medication via a Family Adult Day Care bus driver who will, in turn, deliver such medication to the nurse in charge.

V Self-Administration of Medication

(a) To be considered capable of self-administration of medications, a participant shall be able to:

(1) Identify the medication

(2) Acknowledge the amount of, and schedule for, medication

(3) Remember to take the medication on schedule with infrequent reminders from the staff

(4) Obtain medication from its container without assistance or with minimal assistance.

(b) Medications brought to Family Adult Day Care for self-administration must comply with the information in # I-IV above.

VI CONSENT FORM – This form must be signed for medications to be administered by nursing staff.

I have read the medication policy and : (1) agree to the terms and conditions therein, (2a) give the nursing staff permission to give _______________________ his/her prescribed medication(s) or (2b) will be self-administering my medications based on the terms in section V above.

____________________________________ Date: _________________________

Signature of Participant or Responsible party