

Or Medication Administration Request received from Residential Support Provider: (must be on approval from the guardian or physician)

_____ **Print Name**

_____ **Signature of Residential**

_____ **Date**

** Note to Residential Staff – by signing you are indicating that you have received consent from Guardian for this medication to be administered.*

**In extraordinary circumstances where additional medications may need to be administered. For example day or camping trips consent must be given by the guardian.*

Consent given by telephone, staff signature/date: _____

To be reviewed annually. If no changes, please sign and date.

Signature of Guardian: _____

Date: _____

Signature of Guardian: _____

Date: _____

Signature of Guardian: _____

Date: _____