APPROVAL TO SELF-ADMINISTER MEDICATION

In accordance with IDAPA 16.03.19.401, prior to giving the resident responsibility for administering medications without assistance, the CFH provider must obtain approval from the resident's healthcare 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 CFH provider must have this assessment reevaluated by the healthcare professional. The healthcare professional has evaluated the resident as follows:

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 of prescribed drugs and knows what actions to take in case of an emergency.	Yes ☐	No ☐
The resident does not require assistance or reminders to take the medications.	Yes ☐	No ☐

HEALTHCARE PROFESSIONAL APPROVAL

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

Printed Name:	Business Phone:
Practice Name:	
_____ HEALTHCARE PROFESSIONAL'S SIGNATURE	_____ DATE

CERTIFIED FAMILY HOME PROVIDER

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

Provider Name:		
Phone Number:	Email:	
Mailing Address:		
Mailing City:	Mailing State:	Mailing ZIP: