



# AUTHORIZATION FOR RESIDENT TO SELF-ADMINISTER MEDICATION

Dev. 1990 (Rev. 11/06)

NAME: \_\_\_\_\_ RECORD #: \_\_\_\_\_

I release Lutheran Family Services in the Carolinas and its employees from any liability that may occur as a result of the above-named resident's self-administration of the following prescribed or non-prescribed medication(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This authorization is fully understood and is made voluntarily on my part. Note: A physician must approve self-administration for all clients.

\_\_\_\_\_  
Signature of Resident/Date

\_\_\_\_\_  
Signature of Guardian (if applicable)/Date

\_\_\_\_\_  
Signature of Physician/Date

\_\_\_\_\_  
Signature of Program Director/Date

This form must be signed by the physician when medications are changed (exception change in dosage) or annually.

*attach physician's orders if available*