Directions: This form **must** be completed, as per the Medication Administration Agreement, prior to any Self-Directed Employee (SDE) giving medication. In such situations, a copy of this form must always be available to the SDE (consumer and/or authorized representative to determine exact location within the work site). This form must be updated whenever changes are made, or at a minimum, once per year. **Please complete and return this form to our Customer Service Team at**: awccustomerservice@nj.easterseals.com.

If the SDE is not giving medication, the medical history is still requested in case of emergency.

|  |
| --- |
| **Consumer Information:** Complete each area of this section |
| Name: |  | Date of Birth:  |  | Gender: |  | Height: |  | Weight: |  |
| Address |  | City: |  | State: |  | ZIP: |  |
| Home Phone: |  | Cell Phone: |  | Email: |  |

|  |
| --- |
| **Emergency Contact:** Complete all information. By providing this information, you are authorizing release of medical information to this person |
| Name: |  | Address: |  | City: |  | State: |  | ZIP: |  |
| Home Phone: |  | Cell Phone: |  | Email: |  |
| Relationship: \_\_\_\_ Care Provider \_\_\_\_ Parent \_\_\_\_ Sibling \_\_\_\_ Other: |

|  |
| --- |
| **Guardianship Information** |
| Do you have a legally appointed guardian, medical conservator, or who has durable power of attorney? \_\_\_\_Yes \_\_\_\_No*If yes, please complete the information below:* |
| Name: |  | Address: |  | City: |  | State: |  | ZIP: |  |
| Home Phone: |  | Cell Phone: |  | Email: |  |

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| --- |
| **Allergies:** |
| Do you have any allergies? (Include foods, medications, environment, etc.) \_\_\_\_Yes \_\_\_\_No *If yes, please complete the information below:* |
| Allergic to what? | What was the reaction? | Did you seek medical treatment? |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

|  |
| --- |
| **Medical Care Providers:** |
| Hospital of preference: |  |
| Primary Doctor Name: |  | Primary Doctor Phone: |  |
| Does the consumer see any specialists? \_\_\_\_Yes \_\_\_\_No *If yes, please complete the information below:* |
| Specialty | Name | Phone |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| Insurance Company: |  | Policy Number: |  |
| Medicaid Number |  | Medicare Number: |  |

Medical History Questionnaire:

|  |  |
| --- | --- |
| Are you on a special diet?  |  \_\_\_\_\_ Yes \_\_\_\_\_ No |
| If yes, what are your dietary restrictions?  |
| Do you have any history of organ issues or malfunction? |  \_\_\_\_\_ Yes \_\_\_\_\_ No |
| If yes, what organ(s): \_\_\_ Heart \_\_\_ Liver \_\_\_ Lung \_\_\_ Kidney \_\_\_ Bowels \_\_\_ Other |
| Please explain: |
| Do you have any chronic conditions? |  \_\_\_\_\_ Yes \_\_\_\_\_ No |
| If yes, what: \_\_\_ Seizure disorder \_\_\_ Diabetes \_\_\_ Arthritis \_\_\_ High Blood Pressure \_\_\_\_ Low Blood Pressure\_\_\_ Other |
| Please explain: |
| Is there any other pertinent medical information that your caretakers/SDE should know? If yes, please note it here: |
| Do you take any medications (prescription, OTC, or supplements? |  \_\_\_\_\_ Yes \_\_\_\_\_ No |
| If yes, check which applies: \_\_\_\_ SDE will be administering medications \_\_\_\_ Medications administered by family/guardian \_\_\_\_ Medication not needed during SDE’s shift \_\_\_\_ Individual will self-administer medications |

***If medication administration is approved as a service provided, complete the medication information on the following pages in addition to the Medication Administration Agreement form, which must be returned to Easterseals NJ***

|  |
| --- |
| **Medication History: List ALL current prescription medications:** |
| Name of Medication | How much do you take?*Ex. 5 mg tablet* | When do you take it? | Why do you take it? | Do you have any problems or concerns with this medication? |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |

|  |
| --- |
| **Medication History: List ALL Over-the-Counter Medications, Supplements, Herbal remedies, etc.**  |
| Name of Medication | How much do you take? | When was the last time you took it?  | Why do you take it? | Do you have any problems or concerns with this medication? |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |