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**Agency with Choice Medication Administration Agreement**

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Self-Directed Employees (SDE) may administer medications to a service recipient in his/her care. The SDE must complete and pass all the DDD College of Direct Support Medication Trainings, Medication Practicum and review the service recipient’s Health and Medication History.

1. Medication Basics
2. Working with Medications
3. Administration of Medications and Treatment
4. Follow-up Communication and Documentation of Medications
5. Medication Practicum (On-Site Competency Assessment)
6. Health and Medication History Form

NO SELF-DIRECTED EMPLOYEE MAY ADMINSITER ***ANY*** \*MEDICATION, UNLESS THEY HAVE PASSED ALL PHASES OF THE COLLEGE OF DIRECT SUPPORT MEDICATION TRAINING AND MEDICAITON PRACTICUM.

\*Medication includes but not limited to prescription medications, over the counter medications (headache, cough, eye drops, etc.), emergency medications (epi pen, nitroglycerin, inhaler for asthma, etc.) vitamins, supplements, creams/ointments, etc.

The service recipient, family member/guardian must adhere to the following:

**General Requirements:**

* Complete and review the Health and Medication History Form with SDE.
* Observe the SDE administer medication as part of the Medication Practicum and complete the New Jersey Division of Developmental Disabilities Medication Administration Evaluation Form.
* If possible, obtain copies of prescriptions for medications to be administered by the SDE.
* The information on the prescription and the pharmacy label must match.
* Medications must be current, must have most current prescription.
* For each medication the SDE administers, he/she shall have a copy of the medication information insert

that was included when the medication was filled.

* The service recipient’s medications must be stored in a box/container/baggie that is separate from the

other members of the household’s medication.

* Medications must be stored in a secure place out of the reach of possible consumption, but accessible to the SDE.
* Medications will be administered as prescribed. Medications cannot be altered, crushed, hidden in food, diluted, etc., unless written on a prescription or a physician’s note.
* Only one person, either the SDE or the family member/guardian, will administer the medication during

the SDE’s shift.

* Upon arrival the SDE will check to ensure all medications and supplies are available to administer

medications. If they are not, the SDE will not be able to provide services until all the medications and

supplies are available.

**Prescription Medications:**

Prescription medications must be in the original labeled pharmacy container and contain the following:

* First and last name of the service recipient
* Date medication was ordered/date it was filled
* Name of medication
* Type of medication
* The dosage
* Times for administration (specific time or number of times to be taken)
* Correct administration route and
* Special administration or storage instructions, if necessary

**Over-the-Counter medications:** These are medications that normally don’t require a prescription. Some over-the-counter medications are used every day, like vitamins, nutritional drinks etc. Other over-the-counter medications are taken when the person is not feeling well, like an antacid for upset stomach, cough syrup or ointment for a rash.

Over-the-counter medications **WILL** require a prescription or a physician’s note, and a label to affix to the medication, vitamins, or supplements which must include:

* First and last name of the service recipient
* Date medication was ordered/date it was filled
* Name of the medication/vitamin/supplement
* The dosage
* **The specified time interval between dosage**
* **The maximum amount to be given in a 24-hour period**
* **The condition under which the medication shall be administered and a stop date.**

**PRN medication (as needed)**,

PRN medications, prescription or over-the-counter medication **WILL** require a prescription or a physician’s note which must include:

* First and last name of the service recipient
* Date medication was ordered/date it was filled
* Name of the medication/vitamin/supplement
* The dosage
* **The specified time interval between dosage**
* **The maximum amount to be given in a 24-hour period**
* **The condition under which the medication shall be administered and a stop date.**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of Managing Employer) understand and agree with the terms and conditions in Agency with Choice Medication Administration Agreement. I understand that if I fail to follow the requirements, the SDE may not administer medication to the service recipient and could jeopardize the service recipient’s health and/or the SDE’s employment for the service recipient.

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Please Print Name of Managing Employer Name of Consumer

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Signature of Managing Employer Date

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Self-Directed Employee, Please Print Name

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SDE Signature Date