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](mailto: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: |  | | | | | | | |

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| **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: | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: |  | | | | |

|  |  |  |
| --- | --- | --- |
| **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. |  |  |  |  |