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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 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 HE/SHE HAS 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.

If Medications ***WILL NOT*** be administered by the Self-Directed Employee.

The service recipient, family member/guardian should initial the reason why the SDE will not be administering medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_The service recipient does not take any medications

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medications are not taken during the times of the SDE’s shift

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medications will be administered by the family member/guardian

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of Managing Employer) understand and agree that the SDE ***will not*** administer ***ANY*** medication to the service recipient.

I further understand, if the need arises for the SDE to administer medications, the SDE will not be allowed to do so until he/she has completed the mandatory Medication Trainings, Medication Practicum and Health and Medication History review. In addition, I must agree with terms and conditions and sign Agency with Choice’ Medication Administration Agreement PART B.

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Please Print Name of Managing Employer Name of Consumer

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Managing Employer Signature Date

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Self-Directed Employee, Please Print Name

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SDE: Signature Date