Medication Administration Agreement Procedure

PURPOSE: To ensure the Managing Employer understands and agrees to the terms and conditions of the Agency with Choice Medication Administration Agreement (EMAA).

Declines Medication Administration: The Managing Employer will decide if the Self-Directed Employee (SDE) will be administering medication to the consumer as part of the SDE's job responsibilities. If the Managing Employer decides no medication will be administered by the SDE, the Managing Employer will select and signoff on one of the following:

- The consumer does not take medication.
- The consumer will not be taking medication during the time of the SDE's shift.
- The Managing Employer will administer all of the consumer's medications.

Medication Administration: If the Managing Employer requires the SDE to administer medications as part of the SDE's job responsibilities, the Managing Employer must agree to the terms and condition in the EMAA. If the Managing Employer does not agree to all the terms and conditions of the EMAA, then the SDE will not be authorized to administer medication to the consumer.

If the SDE had not been administering medication as part of his/hers job responsibilities, but the Managing Employer now requires the SDE to administer medication, the Managing Employer must now agree to the terms and conditions in the EMAA. If the Managing Employer does not agree to all the terms and conditions of the EMAA, then the SDE will not be authorized to administer medication to the service recipient.

No SDE will administer any medication until they have completed and passed the College of Direct Support Medication Trainings and Medication Practicum (the on-site competency assessment).

- The Managing Employer will conduct the On-Site Competency Assessment
- The Health and Medication History form must be completed as a requirement of the SDE Medication Administration and reviewed as part of the On-Site Competency Assessment.

Agency with Choice Medication Administration Agreement

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's Medication Administration Agreement PART B.

_____ _____
Please Print Name of Managing Employer Name of Consumer

_____ _____
Managing Employer Signature Date

_____
Self-Directed Employee, Please Print Name

_____ _____
SDE: Signature Date

Health and Medication History Procedure

PURPOSE: To ensure Self Directed Employees (SDE) have access to the consumer's health and medication history as part of the Self-Directed medication administration.

1. The Health and Medication History form, although not mandatory, will be asked to be filled out for each consumer.

2. The Health and Medication History form ***must*** be completed as a requirement of Self-Directed Employee's Medication Administration.

3. The Health and Medication History form is to be completed, signed by Managing Employer and reviewed as part of the SDE Medication Practicum (the on-site competency assessment).

4. The Health and Medication History form shall be updated by the Managing Employer whenever there is a change in the consumer's health history or medication.

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Health and Medication History

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.

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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Health and Medication History

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:	

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Health and Medication History

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	

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Health and Medication History

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.				

Financial Management Services Agency with Choice

Health and Medication History

4.				