



PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

NAME: _____ **BIRTHDATE:** _____

The following guidelines govern the administration of medication to clients at GRAFTON:

1. Authorization for medication is required from the parent or legal guardian.
2. Prescription medication (psychotropic) will be administered with review and approval by a psychiatrist.
3. Medication will be administered only by persons who have received training in medication administration.
4. Medications prescribed prior to the client's enrollment will be continued under the guidelines indicated above and only under the following conditions:
 - a. a copy of the prescription is provided; and
 - b. a 3-5 day supply of the medication is provided.

I understand that monitoring of this medication must occur by an appropriate physician. I understand that I will be kept advised of all doctor visits and any proposed medication changes.

I hereby authorize administration of medication to the above-named child as prescribed by appropriate physicians. I understand that this medication will be administered by the staff of GRAFTON, INC., under the direction of the prescribing physician.

Signature of Parent/Guardian

Date