Medication Administration Authorization

I understand *TRANSITIONS for the Developmentally Disabled* is a licensed State of Arizona Provider of Services for the Division of Developmental Disabilities. I understand that the State of Arizona allows non-licensed care-givers to administer oral medications when a client's parent/guardian has personally instructed and trained supervisory staff in the proper administration of such medications.

I, _____, the parent/guardian of _____ , a client of *TRANSITIONS*, hereby authorize care-givers of *TRANSITIONS* who have been trained in medical administration and properly instructed by supervisory staff to administer the following medications:

******PLEASE INCLUDE ANY AND ALL OVER-THE-COUNTER MEDICATIONS YOU AUTHORIZE ON THE LIST BELOW:******

	MEDICATION	DOSAGE (mg / times per day)	PURPOSE OF MEDICATION
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

_____ _____
Parent/Guardian Date

_____ _____
Supervisory Staff Date

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