The Respite Connection Medication Authorization Form

Consumer's Name: _____ **Medicaid #:** _____ **Date of Birth:** _____

Parent/Guardian Signature (authorizing staff to give these medictions): _____

Staff must sign, write time & initials below the date of the medication given, after each dose.

Name of Medication: **Wellbutrin SR** Special Instructions: take with some food, no grapefruit products while taking this mediction	Dose: Strength (mg) & Amount (#of pills): 150 mg tablets, take 2	Times & Frequency: take at 8am and 4pm	Route of Administration: oral	Prescribing Dr. or Over-the-Counter? Dr. John Smith	Start & End Date 1/9/12-5/1/12

Month: _____ **Year:** _____

Staff must initial each time and date medication is given

Staff's Signature:	**Time Given, include AM or PM**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Jane Does' Signature	8:00 AM		**JD**			**JD**				**JD**				**JD**	**JD**	
Jane Does' Signature	4:00 PM				**JD**			**JD**						**JD**		

Name of Medication: Special Instructions:	Dose: Strength (mg) & Amount (#of pills):	Times & Frequency:	Route of Administration:	Prescribing Dr. or Over-the-Counter?	Start & End Date

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Staff's Signature:	**Time Given, include AM or PM**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

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