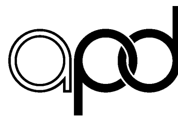

agency for persons with disabilities
State of Florida

<u>Authorization for Medication Administration</u>

APD Client's Name_____________________________________ Date of Birth ___________

Health Care Provider ____

I am a physician, physician's assistant, or advanced practice registered nurse licensed or authorized to practice in the State of Florida, and a provider of health care services for the above-named client receiving services from the Agency for Persons with Disabilities.

It is my professional opinion, based on my knowledge of his/her health status and physical condition that he/she is:

______ Fully capable of self-administering his/her medications without supervision; <u>or</u>

______ Requires supervision while self-administering his/her medications; <u>or</u>

______ Requires medication administration assistance; <u>or</u>

______ Requires medication administration assistance, with the following exceptions for which the client is fully capable of self-administering without supervision (specify route): _______________; <u>or</u>

______ Requires supervision while self-administering his/her medications, with the following exceptions for which the client is fully capable of self-administering without supervision (specify route): _________________

____ ____________________________

Health Care Provider's Signature Date of Authorization