**Physicians Order Form**

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| Client’s Name:  |  | DOB:  |  |

Qualified staff will administer prescription medication if the following conditions are met:

1. The Physicians Order Form must be completed and signed by the prescribing physician and responsible party if SJV will be responsible for administering medications.
2. The Physicians Order Form clearly indicates the client’s name, medication, side effects, dosages, times, frequency and route of administration.
3. The medicine must be received in the original prescription bottle or container with an unaltered pharmacy label attached and matches the Physicians Order Form.
4. The physician must provide SJV staff with current information each time the medication or its directions are changed in any way (i.e.- type of medication, time, frequency or dosage of medication). An updated form must be completed and signed by the Physician and entered into the files prior to the next scheduled dosage.
5. “Over-the-counter” medications that are restricted will not be administered. If the physician indicates the need for administration of “over-the-counter” medications, the responsible party must provide the medication to staff.
6. All medications will be kept secured in accordance with State regulations.
7. Parent or Legal Guardian is responsible for all medication transfers to and from the service.

\*Check in “SJV Admin” if medications are to be administered by SJV.

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| --- | --- | --- | --- | --- | --- |
| **SJV Admin** | **Medication Name** | **Diagnosis/Purpose** | **Dosage-Strength/Type** | **Frequency/Time of day** | **Route** |
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List any restrictions on over-the-counter medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any undesired/dangerous side effects to look for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any known contraindications with other drugs, supplements or food products that should be noted?

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Are any of the above medications “controlled substances”? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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By signing this form I acknowledge receipt and understanding of St. Joseph's Villa policies regarding medication administration. I further acknowledge that no medications may be administered unless indicated on this form and it is my responsibility to provide Villa staff with a completed form each time medications are changed in any way.

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| --- | --- | --- | --- | --- |
| Prescribing Physician Signature  | Date |  | SJV Representative | Date |
|  |  |  |  |  |
| Client or Parent/Guardian (if minor) |  |  | Relationship to Client | Date |

To be completed by physician upon admission and updated as medications change.

Please fax form to: Child Crisis Stabilization Services at 804-955-4240