ALBERTA PROFESSIONAL SERVICES, INC.

AUTHORIZATION TO SELF-ADMINISTER MEDICATION

I release Alberta Professional Services, Inc. and its employees from any liability that may occur as a result of

____'s

(Name of Client)

self-administration of the following prescribed or non-prescribed medication(s):

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I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This authorization is fully understood and is made voluntarily on my part.

Note: A physician must approve self-administration for all clients.

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Signature of Client and Date

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Signature of Guardian/Parent and Date

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Signature of Physician and Date

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Signature of Agency Representative and Date

This form must be signed by the physician when medications are changed (exception change in dosage) or annually.

This forms meets these standards
Authority: 10A NCAC 27G .0209(c)(2)