agency for persons with disabilities
State of Florida

Authorization for Medication Administration

APD Client's Name______________________ Date of Birth ___________

Health Care Provider ____

I am a physician, physician's assistant, or Advanced Registered Nurse Practitioner licensed to practice in the State of Florida, and a provider of health care services for the above-named client receiving developmental disabilities 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; or

______ Requires supervision while self-administering his/her medications by a validated medication administration assistant; or

______ Requires medication administration by a validated medication administration assistant; or

______________________________ ______________________________
Health Care Provider's Signature Date of Authorization