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 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; or

_____ Requires supervision while self-administering his/her medications; or

_____ Requires medication administration assistance; or

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

_____ 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