Division of Developmental Disabilities Services
Community Services

Self -Administration of Medication Using a Medication Administration Device Approval Form

This verifies that _____ (name) has successfully demonstrated the ability to use a medication administration device per the DDDS Medication Administration Device Healthcare Protocol #6 on_____(date).

The undersigned are in agreement that_____(name) continues to exhibit the interest, ability, and skills necessary to self-medicate using a medication administration device.

Print Name	Signature	Date
Service Recipient		
Registered Nurse		
Case Manager		
Agency Program Manager		
Behavior Analyst (optional)		
Parent/Guardian/Family Member (if applicable)		