Exhibit B

Division of Developmental Disabilities Services
Community Services

Self Administration of Medication Approval Form

This verifies that _____ successfully completed the DDDS Self Medication Program on _____.

The undersigned are in agreement that _____ continues to exhibit/exhibits the interest, ability, and skills necessary to self-medicate.

_____	_____
Individual	Date
_____	_____
Registered Nurse	Date
_____	_____
DDDS Case Manager	Date
_____	_____
Agency Case Manager (If Applicable)	Date
_____	_____
Behavior Analyst (If Applicable)	Date
_____	_____
Parent/Guardian/Family Member (If Applicable)	Date