Family Member Authorization Form

Name of Individual: _____ Date of Birth: _____

Name of family member: _____ Relationship to Individual: _____

This form should be completed by the family for all unlicensed workers to allow them to give/apply prescribed medications and/or perform other health care tasks. By completing the form the family member is verifying that they live with the individual, that they are responsible for the direct supervision of the provider and that they have provided individual specific written training on the individual's medication(s) and any medical procedures to the unlicensed worker providing services to the individual.

Please list the names of the medication(s) (insert name) is currently taking. Also include any special instructions for administration of each medication.

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Please list any health care tasks that (insert name) requires. Also include any special instruction for each of the task.

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Upon completion of this form I will send a copy to:
Montgomery County Board of DDS
Attn: MCBDDS Quality Assurance Nurse
580 Calumet Lane
Dayton, OH 45417

Signature of Family member: _____ Date: _____

Signature of provider: _____ Date: _____