

**MEDICATION HOME AGREEMENT**

Your friend or family member needs assistance to assure that they receive needed medications when away from their normal support staff.

When taking your friend or family member away from their normal supports, you are assuming the responsibility to assure that your friend or family member will receive the support needed to ensure they receive their medications or other treatments as ordered for the time frame from \_\_\_\_\_ to \_\_\_\_\_.

**Name of Medications and times to be given:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any special instructions or monitoring needed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Person receiving Support

\_\_\_\_\_  
Responsible Party Date

\_\_\_\_\_  
Staff Person Assisting Providing Medications & Information Date