995 Worthington Street, Springfield, MA 01109
Telephone (413) 734-5376 FAX (413) 737-7949

Medication when on Leave of Absence from Program form

Participant Name: **Program Name:**

Date and Time of Departure: **Date and Time of Return:**

Traveling alone? **(If no, specify with whom)** **YES _____ No_____ :** _____

MEDICATIONS: For each medication and strength specify exactly as on the Prescription label

Name of medication	Strength of medication	Dose / (Number of Pills to take at that med time)	Route	Frequency (add times person normally takes the medication)	# of Pill Provided	Side Effect Sheets Provided

Special medication instructions/comments or allergies (e.g. side effects, cautions / use back if more room needed)

Staff who Prepared Medication **DATE**

Staff who Double-checked Medication **DATE**

To who are the medications entrusted? _____I understand the above information regarding medication and its administration. My questions have been answered. I also understand I may call the staff if any further questions arise at _____ (Program Number)

Signature of Person Entrusted w/ Medications **DATE**

Signature of Staff and Title **DATE**