Division of Developmental Disabilities Services
Community Services

Self Administration of Medication Assessment Form

Individual: _____   **MCI Number:** _____

Date of Birth: _____   **Date of Assessment:** _____

Able to:	Code	Comments
Follow verbal directions and instructions		
Recognize written name		
Comprehend simple number concepts		
Complete hand hygiene		
Identify medication container(s) from others in the cabinet		
Obtain medication from designated locked storage area		
Read and compare medication label with MAR		
State the name and dosage of each medication		
Identify the time of day the medication(s) is to be taken		
Identify the purpose and side effects (at least 2) for each medication		
Remove correct amount of medication from container (i.e., blister pack, card, bottle)		
Swallow medication		
Apply topical medication to prescribed area		
Write date on blister card and initial MAR		
Return medication to designated locked storage area		

Coding:
I – Independent
V – Verbal Prompts
G – Gestural Prompts
P – Physical Assistance
0 – Unable to Complete

Signature of Nurse:_____   Date: _____

1.1.2023