LANCASTER COUNTY
Adult Drug Court
PROVIDING ALTERNATIVES TO INCARCERATION
402-441-8122
fax: 402-441-3606
605 S. 10th St., Room 1163, Lincoln, NE 68508
Jared Gavin, MSW, Drug Court Coordinator

MEDICATION REQUEST FORM

Your Name:_____ Date:_____

All requests to take a medication must be made by filling out this form. No participant shall begin using a medication prior to approval from his/her supervision officer. No participant will be given permission to take a medication that will react or cross-react with drug testing unless the drug court coordinator and/or drug court team determine it appropriate for the participant to do so. There is one and only one exception to this rule. The exception is in cases of a true medical emergency situation (refer to the *Participant's Handbook* for more information on medical emergencies). Supervision officers cannot approve medication that will interfere with drug testing without prior approval from the drug court coordinator and/or the drug court team.

Condition:

Description: _____

_____

Physician Name: _____ Phone #: _____

Date of Last Visit: _____

Prescription Information:

Drug: _____ Strength: _____

Frequency: _____

Pharmacy: _____

Start Date: _____ Duration: _____

Reason for Prescription: _____

Prescription Information:

Drug: _____ Strength: _____

Frequency: _____

Pharmacy: _____

Start Date: _____ Duration: _____

Reason for Prescription: _____

By signing below, I, _____, acknowledge the following:

1. All the information I have provided on this form is true.
2. I have read and understand this form as well as parts of the *Participant's Handbook* pertaining to the use of medications.
3. I will take approved medications only as prescribed or directed.
4. I understand the consequences of taking medications without permission or taking them in a manner other than that prescribed.
5. If the medications I have been given permission to take begin to interfere with my drug testing in any way, I shall discontinue the use of the medication.
6. If I have to discontinue the use of a medication, I shall complete a new Medication Request Form prior to beginning any new medication.

_____ _____

Participant's Signature Date

FOR OFFICE USE ONLY

Type of Condition: Mental _____ Physical _____

Request Granted: YES NO

_____ _____

Supervision Officer's Signature Date

_____ _____

Drug Court Coordinator's Signature* Date

NOTES: _____

_____

_____

_____

**The drug court coordinator's signature is required on all forms when medications that will interfere with drug testing are approved. Otherwise, only the supervision officer's signature is required.*