Medical Administration Consent Form

I \_\_\_\_\_\_\_\_\_\_ confirm that I require the following medication to be taken in accordance with medical advice. I give consent to Decent Care to administer this medication as per the instructions on the medication label.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medicine (print generic name, including strength) | Form | Storage Requirement | Time(s) Required | Dose | Route (how medication is given) | What is this medication used for? | Administration requirements e.g. take on empty stomach. | End Date | Expiry Date | Max Dose Within 24 Hours | Possible Side effects |
|  |  |  |  |  |  |  |  |  |  |  |  |
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Please indicate by circling an option below which of the following actions you would like Decent Care to carry out.

1. Provide medication support which may involve reminding or prompting me to take my medication or assisting me to open medication containers.
2. Provide medication assistance which may involve storing medication, opening medication containers, removing the prescribed dose from the medication containers, and administering the medication as per instructions.

Declaration by Decent Care.

1. A suitably qualified team member will always provide support or assistance with medication when given consent by the participant
2. Decent Care team members will record all instances of medical administration on the participants chart
3. Decent Care team members will ensure that the storage of medication is appropriate for each medication and all medications are kept safely and securely

Participant Signature

Date:

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

Signed:

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

Plan Nominee or Advocate signature (if the participant is under 18 years of age or unable to sign)

Date:

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

Signed:

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