

MEDICATION CONSENT FORM

I _____
(Name of participant)

I _____
(Name of Primary Carer, Parent or Guardian)

agree and give my full consent to *Embracing Ministries* Support Worker/s who have been trained and deemed competent in client medication support and/or administration to provide assistance to **the participant** with their medication as outlined below. Medication support and medication administration is being provided and the type of medications e.g. oral medications, liquid medications, patches etc:

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.....

The participant or the **Consenting Party** on behalf of **the participant** agrees to allow the support worker/s to carry out the above medication support. **The Client** or **the Consenting Party** on behalf of **the participant**.

Name of participant: Date

Signature of Client (if applicable)

Name of Consenting Party: Date:

Signature of Consenting Party: