CONSENT FORM

I give my consent to the Care Workers to assist me with administering medication in accordance with my Service Delivery Plan.

I also agree that arrangements for appropriate storage of my medication is made. This may require:

- **A suitable container/box with a lid.**
- **A lockable box which I will not have access for my own safety and well being.**

  (Delete as applicable)

I also give my consent for the care provider(s) to share relevant information about my care or well being with appropriate health/social care professionals.

Name of Individual: .....

Address: .....

.....

Individual's signature: .....

Date: .....

Signature of person signing on behalf of the individual: .....

Date: .....

Signature of Person gaining consent: .....

Date: .....

A copy of this form must be kept in the individual's records by all agencies providing assistance with medication.