

PARTICIPANT Administration of Medication consent form.

Participant Name:

D.O.B: / /	Name:				
Contact Number: H: M:	Position:				
	Date: / /				
Address:	Emergency Contact pe	Emergency Contact person:			
	Name:	M: H:			
I have advised Life Choice that I do no	ot wish Life Choice Support staff to Admin	ister or Apply any Medication	S		
	• • • • • • • • • • • • • • • • • • • •				
for me. I understand that I will be who	lly responsible for my Medications and the	eir Administration.			
Participant/Parent/Guardian Name:	Signature:	Date: / /			
	_				
Administration of Regular Medicat	ion and PRN Medication.				
I	(Participant / Parent/ Gu	uardian) Circle appropriate			
		, 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Ohio manusianian familifa Ohioina Oima	ant Otaffla a la acca con dantal cara na adia atian	a tandada a anad bassa bassa			

Person completing form.

Give permission for Life Choice Support Staff, who have undertaken medication training and have been assessed as competent to administer or apply Regular prescribed Medication and or PRN Medications under my Doctor's orders. I understand that Life Choice staff are only able to administer prescribed regular or PRN medication that has been prescribed by a Medical Professional and a Medication administration chart is in place. Any regular or PRN medication that has not been prescribed under Doctors orders and is not on a current or new medication chart, is unable to be administered or applied by Life Choice staff. I understand that any separately packed Medication must be labelled by the Pharmacist. If Separately packed medication is not labelled by a Pharmacist, Life Choice staff are unable to administer or apply Medication.

Over the counter (OTC) Medication and Natural Remedy Medicine (NRM)

I understand when OTC or NRM Medication has been recommended under Pharmacist or NRM clinician recommendation or I purchase OTC medication or NRM Medicine independently that has a Therapeutic good number. I am required to have the Pharmacist/NRM Clinician label the Medication and produce a letter to advise Life Choice that the OTC Medications/NRM will not cause any adverse interaction with my Regularly prescribed medication or PRN medication. I understand if the OTC Medication or NRM is not labelled and has not been checked against my Regular Medications and/or PRN Medications, Life Choice are unable to administer or apply the Medication.



I give Permission for Life Choice s	tait to apply the	e following	
Sun Protection lotion/Spray Insect repellent	Yes □ Yes □	No □ No □	
If no has been selected. I understa any Health related impacts this ma			Life Choice as an Organisation from
I give Permission for Life Choice s Medical Professional.	taff to support i	me to have the following	injections under direction from my
Annual Flu injection: Depo Provera injection: Covid 19 vaccination:	Yes □ Yes □ Yes □	No □ No □ No □	
	ces change bef		es to Medication consents in this form. ent review date that I will be required
Participant/Parent/Guardian Name:		Signature:	Date: / /
Medication Administration consent f Participant/Parent/Guardian.	form is to be re	viewed every 2 years, un	nless changes have been advised by
Review Date: / /			