





**CONSENT FORM**

**I give my consent to the Support 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.**