MEDICATION PLAN

Client name _____

Address _____ Date of Birth _____

I, _____ (Participant / Carer / Advocate, hereinafter called "the Consenting Party") agree and give my full consent for staff, who have been assessed as competent in medication support and/or assistance to provide assistance to **the Client** with their medication as outlined below:

Date	Medication	How is it taken? Orally / inhaled etc	Dose	Time	Frequency	Purpose of Medication	Assist Required	Storage Instructions

The Consenting Party agrees to allow the staff to carry out the above medication support or assistance at the risk of **the Participant** as per the pharmacist's instructions on the medication packaging.

Participant/ Client / Carer / Advocate encourage you to keep a current list of:

- all of your current medicines (prescription, non-prescription medicines, and complementary health care products);
- any allergies and previous drug reactions; and
- vaccinations.

Such a list can be very helpful to ambulances and other emergency workers.

Participant/consenting party signature: _____

Date: _____

Name of Doctor or person who prescribed the medication: _____

Phone Number: _____

Signature: _____

Date: _____