

**CONSENT TO ADMINISTER AND SUPPORT WITH MEDICATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GUEST NAME

OR:

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GAURDIAN / PRIMARY CARER

Agree to give full consent to all **STAY AWAYS** staff to administer and support with all Medication as described on the medication Summary attached.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GUEST NAME

Date:

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GAURDIAN / PRIMARY CARER

Date:

All **STAY AWAYS** Staff have been trained and deemed competent to provide and administer medication administration assistance and support.