KAIROS CARE AND SUPPORT SERVICES AUSTRALIA

# Medication Plan and Consent Form

This Medication Plan and Consent Form provides detailed information about the medications you require support with, the type of support and consent for KCSS staff to assist.
KCSS ensures all Clients/Participants have current, accurate and reliable records of medication assistance. This is to support the safe management of medication in the community.

| Client/Participant Name: | Date of Birth: |
|---|---|
| Address: | |

I, _____ (Client/Authorised Representative) [*select one*] hereby give permission and my full consent for KCSS staff to assist with medication management to **the Client** as detailed below.

***I acknowledge that should I refuse to take the medications listed below or chose to administer my own medications, I do so at my own risk, and that staff may notify my medical practitioner.***

| | | Tick Applicable | | |
|---|---|---|---|---|
| **Type of Medication** | **Name/Details** | **Prompt/ Remind** | **Assist (open packet)** | **Administer/ Apply** |
| Webster Pack | | | | |
| Eye Drops | | | | |
| Ear Drops | | | | |
| Inhaler | | | | |
| Transdermal Patch | | | | |
| Medicinal Cream | | | | |
| | | | | |
| | | | | |

The **Consenting Party** agrees to allow the KCSS staff who are appropriately trained and qualified to carry out the above medication support or assistance, as per the pharmacist's/medical practitioners instructions and on the medication packaging.

We require a current list of all current medicines to remain in the home at all times.

Client/Consenting Party Signature: _____

Client/Consenting Party Name: _____ Date: _____

Package Manager/Coordinator Signature: _____

Package Manager/Coordinator Name: _____ Date: _____