Consent to Administer Medication

Privacy Statement
ICAS is collecting this personal information for the purpose of supporting and/or enabling participants to self-administer their medication whilst receiving supports from ICAS. This information will only be accessed by authorised workers. In accordance with the Privacy Act 1988 this information will not be disclosed to any other person or body unless ICAS has been given permission or is required or authorised by law to disclose the information.

1 Complete the Details Below

Participant Name

Date of Birth

Substitute Decision Maker Name

Phone Number

- I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to the participant named above whilst receiving supports from ICAS.
- I authorise ICAS to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this participant.

Name of Medication

I confirm that the medication provided to ICAS (as listed above):

☐ is medically authorised (e.g. has been prescribed by a doctor, dentist, optometrist or nurse

☐ is in the original dispensed container or Webster Pack with intact packaging

☐ has the participants and doctor's names on the pharmacy label (if there is no other written evidence of medical authorisation)

☐ is current/in-date. The expiry date of the medication is

The medication is required:

(a) routinely (e.g. 11am every day) ☐ No ☐ Yes

(b) for a short time only (e.g. only for 2 weeks) ☐ No ☐ Yes

(c) to manage a health condition by following a current action plan or health plan ☐ No ☐ Yes

If Yes to any questions, complete the following:

Administer at ☐ am/pm on the following days:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday
☐ Friday ☐ Saturday ☐ Sunday

Start date:

End date:

Is the medication for:

☐ asthma ☐ anaphylaxis ☐ diabetes ☐ epilepsy
☐ cystic fibrosis ☐ other (describe)

(d) 'as needed' to treat minor or non-emergency symptoms

☐ No
☐ Yes

☐ I understand that before ICAS administers this medication, if they are not aware of when this medication was most recently given, I will be contacted to provide this information.

Has this participant previously shown any side effects after taking this medication? ☐ Yes ☐ No

If Yes, describe:

Participant / Substitute Decision Maker Signature

Date

If the participant is to self-administer this medication, also complete Section 2
NOTE: Controlled drugs cannot be self-administered.

2 Details for Participant Self-Administration of Medication

In all cases and at any time, the Management Team may disallow participant self-administration for health and/or safety reasons.

Participant Name

Date of Birth

- I confirm that the participant is confident, competent and can safely administer the right dose of their own medication at the right times.
- I confirm that the participant can store their medication securely.
- I authorise ICAS Management Team to contact the prescribing health practitioner, health team or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication by this participant.

Health Condition

- ☐ Asthma
- ☐ Anaphylaxis
- ☐ Diabetes
- ☐ Cystic fibrosis
- ☐ Other _____

I seek approval from the ICAS for the participant to self-administer:

- ☐ their asthma medication (following a current action plan/health plan)
- ☐ their adrenaline auto-injector (following a current action plan/health plan)
- ☐ their medication (following a current health plan)
- ☐ their medication (following a current health plan)
- ☐ their medication (following a current health plan)

Participant / Substitute Decision Maker Signature

Date