GNAG Medication Form

Form Completion Date: _____

TO BE COMPLETED BY THE PARTICIPANT OR PARENT/LEGAL GUARDIAN OF THE PARTICIPANT

Participant's Name: _____DOB:_____

Name of Medication as it appears on the label	
P = prescription NP = non-prescription	
Possible side-effects	
Administration Schedule	
Dosage	
Storage Instruction	
Special instructions for taking medicine (with food etc…	

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TERMS AND CONDITIONS FOR GNAG STAFF TO ADMINISTER, SUPERVISE THE ADMINISTRATION OF OR STORE PARTICIPANT MEDICATION. **PLEASE READ CAREFULLY**

1. I agree to provide GNAG staff with:
   - All non-prescription medication in its original container dated and labeled with the clients name. I understand that GNAG staff has the right to ask for a physician's order before agreeing to administer, store or supervise the administration of non-prescription medication.
   - All prescription medication in the original container dated, labeled and supplied by the pharmacist. The label will contain: the participant's name, the physician's name, the name of the medication, the dose, the medication route, the schedule for administration and instruction for storage.
   - Two current photographs if there is a requirement to administer emergency medication, i.e. Epipen®.
2. I agree that GNAG staff may refuse to administer, supervise the administration or store medication where the labels on the medication container(s) do not contain all the information specified above.
3. I understand that not all GNAG staff participating in medication administration are trained health professionals and that the administration of medication is being provided by or, on behalf of GNAG, on a purely voluntary and gratuitous basis. As the participant or Parent/Legal guardian of the Participant/Client receiving medication, I fully understand the nature and extent of the risks involved in administering medication.

I confirm that I have read and understood and completed this agreement. I am aware that by signing this agreement I have agreed to assume full legal liability for all risks involved in having GNAG administer medication under the provisions of this agreement to the named participant.

I authorize GNAG to (Please check the appropriate box):

- ☐ Supervise the named participant in the administration of his/her own medication.
- ☐ Administer medication to the named participant.

Name of Participant (if participant is under 18 years) PLEASE PRINT _____

Name of Parent/Guardian PLEASE PRINT _____

Signature of Participant or Parent/Guardian (if participant is under 18 years) _____

Date: _____ / _____ / _____

GNAG Participant Medication Log

TO BE COMPLETED BY STAFF

Name of Medication: _____

Dose Delivered: _____ Date & Time of Delivery: _____

Name of Medication: _____

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