

Medication Consent Form



HOME AND
COMMUNITY-
BASED
SERVICES
INTEGRATED, PERSONALIZED
COMMUNITY-BASED CARE

Participant Name: _____ Plan Date: _____

Legally Authorized Representative Name: _____

Prescribing Physician(s): _____

(Please list all prescribing authorities)

Consent Agreement: In accordance with Wyoming Statute 33-21-154, I hereby recognize that the individual(s) and/or provider organization(s) listed herein, and employees of the provider organization(s), are known as designated “friends”. I hereby authorize these “friends” to assist the participant named on this form with medication and medical protocols during the following dates: _____ to _____. *(Consent not valid over one year)*

Name of individual(s) or provider organization(s) who have permission to assist:

Waiver providers that assist with medications must do so in accordance with the Division of Healthcare Financing’s standards for medication assistance.

I agree that my providers can administer medications as trained. I have read and understand this authorization, dated _____.

(Participant or Legally Authorized Representative Signature)