Wyoming Department of Health
Behavioral Health Division

Medication **Consent Form**

Behavioral Health Division
Developmental Disabilities Section
Phone: (307) 777-7115
Toll-Free 1-800-510-0280
Fax: (307)777-6047

Participant Name:_____ **Plan Date:**_____

Legally Authorized Representative Name:_____

Prescribing Physician(s), if prescription:_____

Consent Agreement: In accordance with Wyoming Statute 33-21-154, I hereby recognize that the person(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 person(s) or Waiver Provider Organization(s) who have permission to assist:

_____

Waiver providers, who assist with medications, must do so in accordance with the Division'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)