

# Appendix 1 - Healthcare Professional Agreement to Administer Medicine(s) Under Patient Group Direction

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| --- | --- | --- |
| **I:** |  | (Insert name) |
| **Working within:** |  | e.g. Area, Practice |

Agree to administer the medicine(s) contained within the following Patient Group Direction:

**Patient Group Direction for the Supply for Immediate Administration or Administration of lLive Attenuated Intranasal Influenza Vaccine (LAIV) by Approved Healthcare Professionals Working Within NHS Grampian, Highland, Orkney, Shetland, Tayside and Western Isles, Version 1.1**

I have completed the appropriate training to my professional standards enabling me to administer the medicine(s) under the above direction. I agree not to act beyond my professional competence, nor out with the recommendations of the direction.

|  |  |
| --- | --- |
| **Signed:** |  |
| **Print Name:** |  |
| **Date:** |  |
| **Profession:** |  |
| **Professional Registration number/PIN:** |  |