

# 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 Administration of Inactivated Influenza Vaccine 2024/25 Season by Approved Healthcare Professionals Working Within NHS Grampian, Highland, Orkney, Shetland, Tayside and Western Isles, Version 1.0**

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:** |  |