Consent approval for Self Administration of Medication

Name of Young person:_____ **D.O.B:**_____

Risk assessment carried out: ☐ **Yes** ☐ **No** **Date:**_____

- **I agree to self administer medication prescribed for me by my own Doctor.**
- **I will take responsibility to safeguard the medication in my own room at all times.**
- **I will not leave any medication in inappropriate places that allows access to it by any other young person in the home.**
- **I agree to return to staff any medication, part used or obsolete for safe disposal.**

Some medication will have specific storage requirements, for example:

Medication that requires being stored to a certain temperature. Arrangements will be made by staff and through consultation with the pharmacist to accommodate such requirements and in line with Health and Safety procedures within the home.

Signed: **(Young Person)**	**Date:**
Signed: **(Parent/Guardian)**	**Date:**
Signed: **(Social worker)**	**Date:**