**Self-Medication Disclaimer**

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| Name of Service user |  |
| Name of Home |  |

I wish to retain responsibility for storing and administering my own medication. I fully understand that I must keep all my medicines securely in the locked area provided in my room and that I am responsible for their safe storage and use at all times. I am aware and agree to allow staff to check my medication to make sure I am taking it as prescribed.

I understand and accept that the home may wish to assess my capacity at given times and I agree that I have been made aware of the potential risks associated with self-administration of medicines and that this facility may be withdrawn after discussion with myself as appropriate.

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| Any specific guidance or instruction |

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| Service Users Signature |  |
| Date |  |
| Designated Staff Members Signature  |  |
| Date |  |
| Designated Staff Members Name  |  |