**Medication Policy Confirmation**

*This is to confirm that I have read and understood the Home’s Policy for the Safe Handling and Administration of Medication and I agree to follow the procedures within it and to complete all records promptly and accurately.*

*I can also confirm that I have the skills to administer homely remedies and I acknowledge that I will be accountable for my actions.*

*(Staff who give non-prescriptions medicines or other over-the-counter products (homely remedies) to young people should be named in the homely remedies process)*

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| **Name** | **Signature** | **Initials (as on MAR )** | **Date** |
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