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| --- | --- | --- | --- |
| Child’s name  |  | Child’s date of birth |  |
| Children’s Home  |  | Name of Assessor  |  |
| Date completed |  | Role of Assessor  |  |
| Date to be reviewed |  | Date of last medication review  |  |

**This form is only to be used for children aged 16 or 17 years old** who are assessed as lacking capacity to consent to administration of medicines that have been prescribed to them by a qualified medical practitioner.

|  |  |
| --- | --- |
| Does the child fully understand how to administer their own medication (including dosage, route, and timing)? | Yes / No |
| If no, is this the view of other key adults involved in the child’s care (parent/carers, GP, social worker, LAC Nurse)?  | Yes / No / Partly |
| Please provide details of anyone who does not agree with this view (NB. If there is disagreement, the child will not be permitted to self-administer their medication) |  |
| Could the child administer their own medication with support from another person?  | Yes / No |
| If yes, what level of support would they require:  |
| Help to know which medication to take | Yes / No |
| Help to know how much to take | Yes / No |
| Help to know how to take the medication | Yes / No |
| Help to know when to take it | Yes / No |
| Help to physically take the medication | Yes / No |
| Other (please state): | Yes / No |
| Does the child need to have support with learning how to administer their medication?  | Yes / No |
| Date attended |  | Date refresher training due |  |
| Has the child’s competency to self-administer been observed by a qualified practitioner?  | Yes / No |
| Date of competency assessment |  | Name of person observing competence |  |

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| --- |
| Current medications and how to take them  |
| Name  | Dosage  | Time to be taken  | Route to be taken  | Other important information  |
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| How and where will medicines be stored?  |
|   |

We hereby consent that the above named child will be supported to self-administer their medication following the guidelines described above. We understand that this arrangement will be reviewed every 6 months, or after any medication incident or error and may be withdrawn depending on any change in the identified risks.

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| --- | --- | --- | --- | --- | --- |
| Name of child  |  | Signature  |  | Date |  |
| Name of Assessor  |  | Signature  |  | Date |  |
| Name of Registered Manager  |  | Signature  |  | Date  |  |
| Name of LAC Nurse |  | Signature  |  | Date  |  |
| Name of Social Worker  |  | Signature  |  | Date  |  |
| Name of GP  |  | Signature  |  | Date |  |
| Name of Pharmacist  |  | Signature  |  | Date |  |
| Name of Parent |  | Signature  |  | Date |  |