|  |  |  |  |
| --- | --- | --- | --- |
| 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.

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| --- | --- | --- | --- | --- | --- |
| 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 | |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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understand that this arrangement will be reviewed every 6 months, or after any medication incident or error and may be withdrawn depending on any change in the identified risks.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 |  |