

**Self-administration of medicine resident consent**

<b>Resident's name</b>	
<b>Date of birth</b>	

- I have read and understood the self-administration of medicines information leaflet.
- The self-administration of medicines has been fully explained to me.
- I am willing to take responsibility for my medicine and will store them in the lockable medicine bedside cabinet provided.
- I will keep the key safe.
- I understand that I must not share my medicine with anyone.
- I know that I must inform a staff member immediately if someone else tries to take my medicines, if my key is lost or missing or I have any other problems with my medicines.
- I understand that I may withdraw from self-administration at any time without prejudice, by informing the care home staff.
- I understand that I may be withdrawn from the scheme if a member of the nursing team believes it is in my best interests.
- I agree to accept responsibility for the safe keeping of my medicines and any consequence of failing to take my medicine in the prescribed way.

<b>Resident signature</b>	
<b>Staff name</b>	
<b>Staff signature</b>	
<b>Date</b>	