

Service User Oral Self-Medication - Declaration of Competency

STAFF MEMBER:		ASSESSOR:			
Service User:		G.P:			
ORAL MEDICATION (tablets & capsules)					
1	_____	2	_____		
3	_____	4	_____		
5	_____	6	_____		
7	_____	8	_____		
	COMPETENCY ELEMENT	Signature of SERVICE USER	Date	Signature of CARE STAFF / WORKER	Date
1	I would prefer to manage my own medication, and a Risk Assessment has been completed				
2	I wish to order my medication from the GP myself OR I would prefer staff to do so				
3	I understand that my medication must not be given to anybody else but myself				
4	I agree to keep medication safely stored when not in use				
5	I understand that Care Staff can access my medication if necessary				
6	I am able to read and understand instructions on medicine containers				
7	I understand the medicine dosages to be taken, and I will administer tablets etc myself				
8	If I lose a tablet, or take it wrongly, I will advise the Care Staff immediately				
9	If I am in difficulty I will seek advice from the Care Staff				