

# COMMUNITY MEDICATION AUTHORITY FORM

Surname: \_\_\_\_\_ Forename: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ NHI Number: \_\_\_\_\_

Address: \_\_\_\_\_

General Practitioner: \_\_\_\_\_ Weight: \_\_\_\_\_ (12 years or under only)

**ALLERGIES** This section must be completed before administration of any medication

Allergy/Reaction To (name drug or substance)	Type of Reaction

## PRESCRIPTION

Drug	Dosage	Route	Frequency

**THE ABOVE MEDICATIONS MAY BE INCREASED/DECREASED TO/BY**


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Last given in hospital (date/time) \_\_\_\_\_

First administration in the community at (date/time) \_\_\_\_\_

In the event of an anaphylactic reaction, the nurse will carry out the procedures set down in the Community Health Management of Anaphylaxis Policy June 2004 (incorporated with WDH B Medicines Management Policy).

Doctor's Name Printed	Specimen Signature	Date
Doctors Address		

Expiry Date: \_\_\_\_\_

Review Date : Jan 2008