Prescribed Regular Medication Record

Please use **black ink** and CLEAR WRITING when filling out this document as policy. Please input CONTROLLED DRUGS onto form (MH1b) as supplied.

Child's Full Name: Date of Birth:

Any known allergies/sensitivities: Nil known (Refer to child's care plan)

Generic Medicine Name & Type (tablet, liquid etc)	Strength of Medicine	Dose Prescribed	Route of Administration	Time/s to be Given	Health Professionals Signature/Date

It has/has not been agreed that the child/young person named above is able to safely self administer their own prescribed medicines.

Comments/guidance on self administration (Refer to Care Plan)

Health Professional's Signature..... Date.....

Other signature..... Date.....