



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

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: _____