CONFIDENTIAL MEDICATION AUTHORITY FORM/ TREATMENTSHEET FOR PRESCRIBED AND NON PRESCRIBED MEDICATION

PARTICIPANT:		**DOB:**	
PRESCRIBING DOCTOR NAME:		**TEL:**	
PRESCRIBING DOCTOR SIGNATURE:		**DATE:**	

☐ Participant self administer ☐ Participant requires support with administration

IMPORTANT INFORMATION

- This form is to be completed by the prescribing Doctor and must clearly state the name of the medication, the dosage, the route and frequency of administration
- Staff will not administer medication unless this form has been completed and signed by the prescribing Doctor
- Staff will not administer medication unless this form has been sighted at the time of administration

Medication (print clearly)	Reason For Medication:	Dosage	Route	Form (liquid /tablet)	FREQUENCY i.e. 7am & 4pm,	Known Side Effects	Doctors Signature
Eg. Berilium	*Epilepsy*	*100mg 3x daily*	*Oral*	*Tablet*	*8am, 12pm, 5pm*	Dizyingess	

Special Instructions: (eg. Tablets can be crushed and put in liquid, how the person likes to take their medication)

Allergies: