Prescribed Only Medicine (POM) Consent Form

Student Name: _____ **Date of Birth:** _____

Address: _____

Signature: _____ **Relationship to student:** _____

Medical surgery: _____

Allergies: _____

Register of Medication Obtained

Date	Name of Person Who Brought it in	Name of Medication	Amount Supplied	Form Supplied	Expiry Date	Dosage Regime	Received By

Register of Medication Administered

Date	Name of Medication	Amount Given	Amount Left	Time	Administered and Witnessed by	Comments/Action/Side Effects

Register of Medication Administered - continued

Date	Name of Medication	Amount Given	Amount Left	Time	Administered and Witnessed by	Comments/Action/Side Effects