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| Name of Child |  | Name of Medication |  | D.O.B |  | Chronological No: |  |
| Duration Of Course |  | Dose |  | Route of Administration  |  | Times to be given |  |
| Known Allergies |  | **If medication is not given – Enter a reason using a code in comments box** | **CODES****R** – Refused, **NBM** -Nil by Mouth, **V** – Vomited, **NA** – Not available, **O** – Omitted, **A** – Asleep, **L** – Child absent/Leave, **UTF** – Under the influence |
| Date prescribed |  | Date Received |  | Quantity Received /expiry date |  | Reason for medication: |  |

Space for Picture of YP

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| Address of Child:  |
| Address of GP |
| Next of kin:**.**  |
| Young Person Weight (and date taken: |
| Any additional comments:  |
| Any new or known side effects to this medication:  |

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| **Checked in by?** | **Witnessed by?** |
| Carer name: Role:  | Carer name: Role:  |
| Carer sign: | Carer sign: |

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**Refer immediately to GP if any signs of side effects: refusal for 3 or more consecutive days refer back to GP / ensure health care plan is updated.**

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| **This document was completed at………………….AM/PM on…………………….Day / /** **By: (Print name)………………………………….Role…………………………………Signature…………………………** | **Checked by: (Print name)****Role: Signature:** |
| **IMPORTANT – HAVE YOU GENERATED AN EXTRA COPY OF THIS CHART, AFTER COMPLETION? SCHEDULES 3 8 4 OF THE CHILDREN’S HOMES REGULATIONS 2001 REQUIRES THAT YOU KEEP TWO COPIES OF EACH CHILD / YOUNG PEOPLES RECORDS. ONCE COMPLETED PLEASE SIGN/DATE BELOW TO CONFIRM THIS HAS BEEN DONE.****Please complete all sections of this form. Seek support from management if you are unsure or have any concerns about this form.** **Ensure that documentation of this form is clear accurate and factual.**  | **YES, I HAVE SCANNED THIS DOCUMENT ONTO LCS IN THE INDIVIDUAL CHILDS RECORDS. THIS WILL BE FILED AND ARCHIVED** **PRINT NAME:** **SIGNATURE:****DATE:** |

**Manager audit checks – Weekly**

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| **Date** | **Comments** | **Print/Sign** |
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| **Date of Disposal /course completed:**  | **Method of Disposal:** **(attach receipt if returned to chemist)**  | **Quantity disposed of:**  |
| **Name of carer disposing:** | **Signature:**  | **Managers Check (Date/Signature)**  |