POM (prescription only medicine) Consent Register

Student Name:Address:						Date of Birth:			
Signatu GP:							Relationship to Student:Allergies:		
Date Date	Name of Person Who brought it in	ined Name of Medication		Amount Supplied		Expiry Date	Dosage Regime	Received By	
Registe	er of Medication Admi	inistered							
Date	Medication		Amount Given	Amount Left	Time	Administered B	Administered By Comments/Action/ Side Effects		
Date	Medication		Amount Given			Administered B	dministered By Comments/Action/ Side Effects		