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| A picture containing icon  Description automatically generated Medical Administration Record |
| Guest Name  |  | **Preferred Name**  |  |
| DOB (DD/MM/YY) |  | **Gender**  |  |  |
| Person Completing Form |  |
| Medical Information  |
| Current Diagnosis |  |  |  |  |
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| Allergies |  |  |  |  |
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| Immunisations  | *Circle which of the following are up to date* |
|  Tetanus Flu COVID-19 Pneumonia |
| Current Prescription Medications Used |
| Name of Medication | **Dosage** | **Frequency** | **Date Medication was Last Taken** | **RegularlyPrescribed(Yes or No)** | **Allergic Reactions or Side Effects** | **Reason Medication is Prescribed** |
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| Any OTC Medications Used |
| Symptom | **Medication & Dosage** | **Frequency** | **Started taking on** | **Last Taken on** | **Side Effects** |
| Pain |  |  |  |  |  |
| Diarrhoea or Constipation  |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| Heartburn |  |  |  |  |  |
| Cough |  |  |  |  |  |
| Congestion/Sinus |  |  |  |  |  |
| Allergies |  |  |  |  |  |
| Sleeping Aid |  |  |  |  |  |
| Skin Problems |  |  |  |  |  |
| Weight loss |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Menstrual Issues |  |  |  |  |  |
| Menopause |  |  |  |  |  |
| Vitamins/Herbs |  |  |  |  |  |
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| Notes |  |
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| --- |
| A picture containing icon  Description automatically generatedRecord of Medication Administered |
| Guest Name  |  | **Preferred Name**  |  |
| DOB (DD/MM/YY) |  | **Gender**  |  |  |
| Person Administering Medication |  |
| Special Notes 1. Medications must be in original box/container marked specifically for guest listed on this form
2. All homeopathic/herbal prescription AND non-prescription medicines require a parent AND physician or nurse practitioner signature. (Physician’s Assistant signature NOT acceptable) \*EXCLUSION: Ibuprofen and paracetamol in age appropriate doses only.
3. Medications must be in date (not expired)
4. It would be preferred that no new medication is introduced just prior or during a DHN placement to avoid adverse reactions

I authorise and request the approved DHN Host administer the medication listed on the attached Medical Record. I understand this form will be updated after each medication is administered. All remaining medication will be taken at the end of this placement.  |
| Guest Signature  |  |
| Parent/Carer Signature |  |
| Medication Administered in Homestay |
| Name of Medication | **Strength****(e.g. 10 mg)** | **Dosage****(e.g. 1 tablet)** | **Route****(e.g. Oral, via PEG)** | **Date Given** | **Time Given** | **Notes** |
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