Please PRINT all your entries! **Bethany Care Ltd - Epilepsy & Medical Authority**

PART A - Epilepsy – TO BE COMPLETED ONLY IF THE CLIENT HAS SEIZURES OR CONVULSIONS

- What was the date of the client's last seizure?____/_____/_____
- Has there been any change to the client's epilepsy record that Bethany should be made aware of? YES / NO. If YES please provide details on a separate sheet.
- Parent's/Caregiver's signature: _____ Date: ____/_____/_____

PART B - Medication Authority – Parents/Carers please complete "Medication Name & Stength", "Dose" and "Directions" columns only.

Client Name & DOB		Parent Name & Phone no		Doctors Name & Phone no	

Insert date of stay through the week period >			Sun		Mon		Tues		Wed		Thurs		Fri		Sat	
Medication Name & Strength	Dose	Directions	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
BREAKFAST																
LUNCH																

TO RECORD MEDICATION DETAILS for DINNER, BEDTIME & PRN, please continue over page

Please PRINT all your entries! **Bethany Care Ltd - Epilepsy & Medical Authority**

Clients Name & DOB		Parent's Name & Phone no:		Doctors Name & Number	

Insert date of stay through the week period >			Sun		Mon		Tues		Wed		Thurs		Fri		Sat	
Medication Name & Strength	Dose	Directions	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
DINNER																
BEDTIME																
WHEN NECESSARY - PRN																

PARENT / CAREGIVER SIGNATURE confirming the above:_____ DATE:_____

This form was checked against medication received by Carer: (Name & Signature):_____