Medication Form

Childs Name: **Date of Birth:**

Please fill out the medication form below:

Please tick the following which apply:

☐ Skin Allergy Cream: Please name which brand if applicable: ________________________

☐ Calpol____

☐ Ibuprofen: Please name which brand if applicable: ________________________________

☐ Sun Cream: Please name which brand if applicable: _______________________________

☐ Inhaler: Please provide name: ____

☐ Plasters: Please name which brand if applicable: _________________________________

☐ Any other cream or lotion which your child may need: ______________________________

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Mother/Carer

Print Name: ______________________Signature: __________________Date: _____________

Father/Carer

Print Name: ______________________ Signature:_________________ Date: _____________