

Medication Form



Childs Name:

Date of Birth:

Please fill out this medication form, which will be kept in your child's room in case needed.

Please tick the following which apply:

Nappy Cream: Sudocream Bepantham Metanium Other

Skin Allergy Cream: Please name which brand if applicable: _____

Teething Gel: 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: _____

Mother/Carer

Print Name: _____ Signature: _____ Date: _____

Father/Carer

Print Name: _____ Signature: _____ Date: _____