**Non-Prescription Medication Record**

**(to be reviewed annually)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CHILD’S DETAILS** | | | | | | |
| Child’s Name |  | | Class | |  | |
| I hereby authorize Teddys Inn Nursery, my child’s Care Provider, to use the following medication/products on my child according to manufacturer or physician’s written instructions. I will not hold the above name provider liable for any allergic reactions or other symptoms when the medication/products are used in accordance with these terms. | | | | | | |
| **Medicine** | | **Symptoms** | | **Remarks** | | **Instructions** |
| Calpol Syrup | | * Fever * Teething pain * Headache | | ** Yes  No** | |  |
| Fenistil Gel | | * Anti-allergy * Insect bites * Itchy skin | | ** Yes  No** | |  |
| Betadine Ointment / Betadine Solution | | * Antiseptic * Superficial wound * Infected dermatoses * Clean infected wound | | ** Yes  No** | |  |
| Fucidine Ointment | | * Minor and major wounds | | ** Yes  No** | |  |
| Arnica Gel | | * Bumps, bruise, strains, etc | | ** Yes  No** | |  |

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Father’s Name / Guardian Mother’s Name / Guardian

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Signature / Date Signature / Date

**Please return the completed form to your child’s class teacher.**