**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** |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature / Date Signature / Date

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