

CONSENT FORM FOR THE ADMINISTRATION OF OVER THE COUNTER/HOUSEHOLD (HOMELY) REMEDIES

‘Name of Service’

I hereby authorise that _____ D.O.B _____ can,
when required, have the following medication at the discretion of the senior
carer/designated person.

DRUG	DOSE	INDICATION
PARACETAMOL TABLETS 500MGS	1-2 TABLETS	MILD PAIN (Max 8 in 24hrs)
SIMPLE LINCTUS	BP5-10mls	IRRITABLE COUGH (Max 4 doses in 24hrs)
STREPSILS	As specified	SORE THROAT
CALAMINE LOTION	As specified	RASH/SKIN IRRITATION

ANY OTHER ?

**ONE OR TWO DOSES MAY BE GIVEN OVER 48HRS THEN IF SOME
SYMPTOMS PERSIST THE PERSON MUST BE REFERRED BACK TO THE
GP/NURSE PRACTITIONER.**

SIGNED DR/NURSE..... DATE