**Homely Remedy Medicines**

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| **Medication** | **What it’s for** | **Age Range** | **For complete dosage directions - follow directions on packaging** | **Cautions** |
| Soluble Paracetamol 500mg | * Mild to moderate pain
* Reducing temperature
* Post vaccination
 | 10 to 15 years (Not recommended for children under 10)16 and over  | One tablet (500mg) every four to six hours (maximum of 4 doses in 24 hours)Two tablets every 4-6 hours when necessary to a maximum of 4 doses in 24 hours[*Guidane taken from EMC*](https://www.medicines.org.uk/emc/product/4199/smpc#gref) | * Dissolve in water prior to administration
* Do not exceed the recommended dose
* Do not administer with other Paracetamol containing products
* Alcohol dependence
* Hepatic impairment
* Renal impairment
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| Simple Linctus BP (2.5%) (Sugar Free) | Dry irritating cough | 12 to 17 years | One 5ml spoonful three to four times a day [*Guidance taken from BNFc*](https://bnfc.nice.org.uk/drug/citric-acid.html) |  |
| Simple Linctus Paediatric BP (0.625%) (Sugar Free) | Dry irritating cough | 1 month to 11 years | One to two 5ml spoonfuls three to four times a day[*Guidance taken from BNFc*](https://bnfc.nice.org.uk/drug/citric-acid.html) |  |
| Klearvol Inhalation Capsules | Nasal congestion  | Not for use in infants under 3 months. | Cut off the tip of one inhalation capsule and squeeze the contents on to a handkerchief, or tissue secured nearby, but avoiding direct skin contact (e.g. pillow case); or into a pint of hot (***NOT*** boiling) water and inhale the vapour freely.[*Guide taken from Klearvol website*](https://www.klearvol.co.uk/products/klearvol-inhalation-capsules) | Do not use boiling water. |
| Strepsils (Sugar Free) | Sore throat | 6 years + | Dissolve one lozenge slowly in the mouth every 2 to 3 hours. Do not exceed the stated dose.[Guidance from EMC](https://www.medicines.org.uk/emc/product/5605/smpc#gref) |  |

**In all cases please read the literature provided with the medication and consult the BNF for Children for further information**

Signature of Medical Practitioner…………………………………………… .Print Name……………………………………………………….

Date……...............