|  |  |  |  |
| --- | --- | --- | --- |
| Name of child: |  | Children’s home: |  |
| Date of birth: |  | Date: |  |
| Child’s Keyworker: |  | Date to be reviewed: |  |
| Date of last CLA medical: |  | Current weight: |  |

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| --- | --- | --- |
| **Known allergies:** |  | **Any Controlled Drugs:** |
|  |  |  |

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| **Current prescribed medication taken on a regular basis**  |
| **Name**  | **Dose**  | **Time**  | **Route**  | **Reason**  |
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| **Current prescribed medication taken on a PRN / ‘as needed’ basis \***  |
| **Name**  | **Dose**  | **Time**  | **Route**  | **Reason**  |
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\* Please see separate Written Plan for each PRN medication

|  |
| --- |
| **Current Non-Prescribed / Homely Remedies /Over The Counter Medicines** |
| **Name**  | **Dose**  | **Date**  | **Route**  | **Reason**  |
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| --- | --- | --- | --- | --- | --- | --- | --- |
| Name  |  | Signature  |  | Role  |  | Date  |  |
| Name |  | Signature  |  | Role  |  | Date  |  |
| Name  |  | Signature  |  | Role  |  | Date  |  |
| Name  |  | Signature  |  | Role  |  | Date  |  |