**Participant Name:** **Date of Birth:**

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| --- | --- | --- | --- | --- | --- | --- |
| **Over-the -Counter (OTC) Medication** *E.g. Cough mixture / Voltarin / some PRN’s / Panadol (not Panadol Osteo as this is a prescribed medication)* | | | | | | |
| Date  .../.../… | OTC Medication  (Use Block Letters) | Dose | Route / Site Applied | Frequency  (e.g. 2xdaily, 4 hourly, lx3weekly) | Review  Date | Discontinued  Date |
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| **Allergies (please print in red)** | | | | | | |
|  | | | | | | |
| **Signature** | | | | | | |
| Signature ……………………………………………………………………………….. (nominee/ doctor / carer / participant) Date:………………………..  Print name……………………………………………………………………………… | | | | | | |

For prescribed medications use CCF-09 Medication Purpose Form – Doctor Approved and/or CCF-28 Participant Treatment Sheet – Summary of Doctor Approved Medications

*Please file this form in the participant’s folder, both as a hard copy and electronically.*