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

|  |
| --- |
|  **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.*