

EXMOUTH GATEWAY CLUB

MEDICATION FORM

This form must be completed for all medication

Name

Home Address

..... Post Code

Telephone..... Date of Birth

Dr.....Surgery.....Phone Number.....

MEDICATION

Name of Medicine	What is it for?	Type (tablet /liquid)	Dosage	Frequency	Side effects
<i>Levothyroxin</i>	<i>Under active thyroid</i>	<i>Tablet</i>	<i>200mg</i>	<i>Nightly</i>	<i>None Known</i>

Continue on another sheet if needed

Special Precautions

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Are we able to give Paracetamol (if required) Yes/No

Are we able to use plasters (if required) Yes/No

Are we able to give Immodium (if required) Yes/No

Signed

Date Relationship to member