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| PRN (when required) Medication Protocol |

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| NAME OF person | **DATE OF BIRTH** |
| **Medication****PARACETAMOL oral****250mg/5ml** | **Dose**two – four 5ml spoonfuls |
| **reason for medication**For the relief of cold and flu symptoms. For pain such as headache.  |
| **How the decision is reached about how and when to give**<Name> is able to ask for medication if s/he has pain. OR<Name> is not able to ask for medication if s/he has pain. Staff must watch for the following signs....... |
| **How often dose can be repeated**Every 4 – 6 hours | **Max in 24hours**4 Doses |
| **Further info. e.g. after food**not to be given with any other product containing Paracetamol unless specifically instructed by the GP |
| **Circumstances for reporting to GP - Tick as appropriate** Persistent need for upper level of dosage Never requesting dosage Requesting too often Side effects experienced Other (please state) |
| **Signature** | **Date** |
| **Review Date…**NB: Please note the review date in the manager’s diary |