

Addressograph/Patient Name and DOB

**DEPARTMENT OF CHILD HEALTH**

**Pain Relief Guidance for Parents/Carers Following Discharge**

**You will need to make sure that you have a supply of the required pain-relief medication at home and follow the dosing guidance below.**

**The Pharmacist/ Doctor will C:\Users\pikema\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\RYNYARR7\tick[1].jpg which medication is required to be taken at home.**

**Always follow the warnings and safety advice on the original container.**

**PARACETAMOL (please tick) Time next dose is due: ………………**

**Please ensure you have the correct strength paracetamol suspension for your child.**

**3 MONTHS - 6 YEARS: Infant and Paediatric suspension 120mg in 5ml  (please tick)**

**Give…..…….ml (= …..…….mg) FOUR times a day**

**6 YEARS AND OVER: Six years Plus suspension 250mg in 5ml  (please tick)**

**Give…..…….ml (= …..…….mg) FOUR times a day**

**12 YEARS AND OVER: 500mg tablets  (please tick)**

**Give ………… tablet/s FOUR TIMES a day**

**IBUPROFEN (please tick) Time next dose is due: ………………**

**3 MONTHS - 12 YEARS: 100mg in 5ml suspension  (please tick)**

**Give…..…….ml (= …..…….mg) THREE times a day, with or after food**

**12 YEARS AND OVER: 200mg tablets  (please tick)**

**Give…..……. tablet/s THREE times a day, with or after food**

**Always follow the warnings and safety advice on the original container.**

**Written by (Pharmacist/ Doctor) ……………………………… Print name ………………………**

**Checked by (Pharm Tech/ Nurse) ……………………………. Print name ...…………………….**

**Date ………………………**