CHILDS NAME: _____ COUNTY: _____

PLEASE LIST ONE MEDICATION PER CARD...

Name of Medication (prescription or over-the-counter)	**Color** (if applicable)	**Form of Medication**	**Dosage** (Amount to be given)	**Breakfast**	**Lunch**	**Dinner**	**Bedtime**	**Taken For**
		❑ tablet ❑ pill ❑ capsule ❑ liquid ❑ inhalant ❑ injection** ❑ other: (specify)_____						

Common side affects/reactions:_____
Remarks:_____
_____

**No injection will be given except in extreme emergency, such as allergy to wasp or bee sting, etc.

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