

Child's Name \_\_\_\_\_ Co/Dist \_\_\_\_\_

**PLEASE LIST ONE MEDICATION PER CARD**

(Attach card with rubber band or string to medication in original container)

Name of Medication	Color (if applicable)	Form of Medication	Dosage (Amount to be given)	Breakfast (AM)	Lunch (PM)	Dinner (PM)	Bedtime (PM)	Reason taking Medication
		<input type="checkbox"/> Tablet <input type="checkbox"/> Pill <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhalant <input type="checkbox"/> Injection** <input type="checkbox"/> Other: (specify) _____						

Common side affects/reactions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Remarks: \_\_\_\_\_

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

\*\* Regular doctor prescription daily injections will be given by nurse, as per orders on medication.

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