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**
		❑ Tablet ❑ Pill ❑ Capsule ❑ Liquid ❑ Inhalant ❑ Injection** ❑ 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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