MEDICAL INFORMATION
(MUST BE FULLY COMPLETED)

MEDICATIONS: PLEASE LIST ANY PRESCRIPTION OR DOCTOR PRESCRIBED OVER THE COUNTER MEDICATIONS YOUR CHILD IS USING:

Drug Name: _____ Dosage ____ per _____

Drug Name: _____ Dosage ____ per _____

ALLERGIES:

Environmental (i.e. pollen, dust) _____

Medications _____

Food _____

DOES YOUR CHILD HAVE AN EPI-PEN? _____

Do they know how to administer it to themselves? _____

HISTORY:

Medical History (be specific) _____
_____
_____
_____

Mental Health Information (be specific)
_____
_____
_____
_____

(ALL INFORMATION IS KEPT CONFIDENTIAL)