EXTENDED MEDICATION INFORMATION

Have you had current tetanus shot? YES NO

Date (MM,YYYY) ____/________

Medications:

All medications will be held by our leaders, then self-administered by the participant. Exceptions are made for asthma, epi-pens, and on a case-by-case basis.

Please describe any recent changes (additions, dose changes, etc.) to the participant's medications:

____

____

Please list all prescription and over-the-counter medications the participant is currently taking:

Medication (1): ____

Dosage: ____

Side Effects: ____

Restrictions: ____

Time(s) administered each day: ____

When it was prescribed: ____

Taking for what condition: ____

____

Medication (2): ____

Dosage: ____

Side Effects: ____

Restrictions: ____

Time(s) administered each day: ____

When it was prescribed: ____

Taking for what condition: ____

____

Medication (3): ____

Dosage: ____

Side Effects: ____

Restrictions: ____

Time(s) administered each day: ____

When it was prescribed: ____

Taking for what condition: ____

____

NAME:_______________