Medications

Remember to include any over-the-counter medicines and supplements your child takes.

Name of Medication	Prescribing Doctor	Strength (see label)	Reason for Medication	Dosage/Frequency (amount)	Start/End Dates	Reason for Ending Medication	Out of Pocket Cost

Pharmacy **Pharmacist** **Address** **Phone Number**

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES: _____

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