ADHEC

ALLERGY	REACTION
Latex Allergy ☐Yes ☐ No	Hgt:__________ Wt:__________

LIST BELOW ALL SCHEDULED AND AS NEEDED MEDICATIONS
INCLUDE OVER-THE-COUNTER, HERBAL MEDICATIONS, INHALERS, EYE DROPS, OINTMENTS, etc.

MEDICATION NAME	DOSE *Please check*	ROUTE	FREQUENCY CIRCLE HOW MANY TIMES A DAY	LAST TAKEN
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
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	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
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	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	

• **Refer to Discharge Instructions for any additional medication usage or prescriptions given today**

SIGNATURE OF PERSON LISTING MEDICATIONS: ______________________________

Confirmed by: ______________________________

MD Signature: ______________________________