CHILD'S NAME: _____ **COUNTY:** _____

PLEASE LIST ONE MEDICATION PER CARD...

Name of Medication (prescription or over-the-counter)	Color (if applicable)	Form of Medication	Dosage (Amount to be given)	Break-fast	Lunch	Dinner	Bedtime	Taken For
		❑ tablet ❑ pill ❑ capsule ❑ liquid ❑ inhalant ❑ injection** ❑ other: (specify)_____						

Common side affects/reactions: _____
Remarks: _____
_____

**No injection will be given except in extreme emergency, such as allergy to wasp or bee sting, etc.

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