MEDICATION FORM

Please list below any medications that your child takes daily or takes intermittently on a regular basis. Please remember to include over the counter medications, vitamin supplements and fluoride. Please also include inhalers, eye drops, ear drops and skin creams. Please include medicines that we have prescribed and medicines that have been prescribed by other providers.

NAME OF MEDICINE	**ROUTE GIVEN** eg. Mouth, g-tube, inhaler, skin, eye, ear, etc.	**DOSE** (in mg if known)	**AMOUNT** eg. 1 pill, 1 teaspoon, 1ml or cc, etc.	**FREQUENCY** eg daily, twice a day, as needed, etc.