Height:________________ WEIGHT_____

ALLERGIES:

Meds:	Food:
	Metals:

Medication Name	Strength (mg)	Dose (1-2 tablets)	Route		Frequency
			By Mouth	Other	
					□_____ times a day □ Every______ hours If needed for_______________________
					□_____ times a day □ Every______ hours If needed for_______________________
					□_____ times a day □ Every______ hours If needed for_______________________
					□_____ times a day □ Every______ hours If needed for_______________________
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					□_____ times a day □ Every______ hours If needed for_______________________
					□_____ times a day □ Every______ hours If needed for_______________________
					□_____ times a day □ Every______ hours If needed for_______________________

Please include over the counter meds.

	Height:_______________ WEIGHT_____

ALLERGIES:

Meds:	Food:
	Metals:

Medication Name	Strength (mg)	Dose (1-2 tablets)	Route		Frequency
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Please include over the counter meds.