SHAC **BSA**

MEDICATION FORM

List ALL prescription AND non-prescription (over the counter) medications currently used. Include any occasionally used medication (prescription and non-prescription) such as inhalers of EpiPens.

Participants Name: ______________________________ Unit # ______________

Medication: ____________________
Strength: ____________________
Frequency: ____________________
Reason for taking this medication: ____________________
____
Approximate Date Started: ____________________
Temporary: __________ Permanent __________
Side Effects: ____________________
____
____
Storage Instructions (if any): ____________________
____
Name of Prescribing Physician: ____________________
Physician's Phone # : ____________________

Medication: ____________________
Strength: ____________________
Frequency: ____________________
Reason for taking this medication: ____________________
____
Approximate Date Started: ____________________
Temporary: __________ Permanent __________
Side Effects: ____________________
____
____
Storage Instructions (if any): ____________________
____
Name of Prescribing Physician: ____________________
Physician's Phone # : ____________________

Medication: ____________________
Strength: ____________________
Frequency: ____________________
Reason for taking this medication: ____________________
____
Approximate Date Started: ____________________
Temporary: __________ Permanent __________
Side Effects: ____________________
____
____
Storage Instructions (if any): ____________________
____
Name of Prescribing Physician: ____________________
Physician's Phone # : ____________________

Medication: ____________________
Strength: ____________________
Frequency: ____________________
Reason for taking this medication: ____________________
____
Approximate Date Started: ____________________
Temporary: __________ Permanent __________
Side Effects: ____________________
____
____
Storage Instructions (if any): ____________________
____
Name of Prescribing Physician: ____________________
Physician's Phone # : ____________________

Medication: ____________________
Strength: ____________________
Frequency: ____________________
Reason for taking this medication: ____________________
____
Approximate Date Started: ____________________
Temporary: __________ Permanent __________
Side Effects: ____________________
____
____
Storage Instructions (if any): ____________________
____
Name of Prescribing Physician: ____________________
Physician's Phone # : ____________________

Medication: ____________________
Strength: ____________________
Frequency: ____________________
Reason for taking this medication: ____________________
____
Approximate Date Started: ____________________
Temporary: __________ Permanent __________
Side Effects: ____________________
____
____
Storage Instructions (if any): ____________________
____
Name of Prescribing Physician: ____________________
Physician's Phone # : ____________________

PHOTOCOPY MEDICATION FORM AS REQUIRED