Medication/Emergency Contact Information

Name _____

ID Number _____

Name/Credentials of Staff Initially Completing the form:

Intake ☐ Annual ☐

Date Initially Completed:

CURRENT MEDICATIONS

List ALL known and/or reported medications the individual is currently taking regardless of type or purpose to include over-the-counter (OTC) medications (use additional pages, if needed):

Staff Signature/ Credential	Date Initiated	Name of Medication	Prescribed by	Dosage/ Frequency	Date Terminated/ Changed	Staff Signature/ Credential

Known Allergies/Reactions:

PREVIOUS MEDICATIONS

Medication	Directions	Comments (to include adverse reactions if applicable)

Special Dietary Needs *(if applicable)*:

Emergency Information:

In case of emergency (when parent/legal representative cannot be reached) contact:

Name:

Phone Number: **(primary)** _____ **(secondary)** _____

Address:

Primary Doctor:

Doctor's Phone:

Doctor's Address:

Hospital Preference:

Insurance Carrier(s):

Policy Number(s):