NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

NEW PATIENT MEDICATION LIST

PATIENT IDENTIFICATION

1. Today's date: _____

_____ _____
Child's Name (please print) Child's Birth Date

_____ _____
Your Name (please print) How are You Related to the Child?

2. Is the child allergic to any medicine, vitamin, or herbal or has he/she had a bad reaction to any medicine, vitamin or herbal in the past? *(circle yes or no)*

Yes No

2a. If "yes," please list the name(s) of the medicine, vitamin or herbal and describe what happened:

Name of medication, vitamin or herbal	What happened to the child? (describe the allergic reaction)

3. Is the child currently receiving breast milk? *(circle yes or no)* Yes No
(*Some medications taken by a mother can be passed on to the child through breast milk*)

3a. If "yes," please list the names of all medicines, vitamins and herbals the mother is taking:

_____

4. Which pharmacy fills your child's prescriptions? _____ _____
Pharmacy Name Pharmacy Phone Number

5. Please list the names and doses of all medicines, vitamins, herbals and over-the-counter medicines the child is currently taking:

Name of medication, vitamin or herbal or over-the-counter medicine	How much does the child take? (dosage)	How often? (frequency)

(Continued on next page)

_____ _____
Practitioner Signature Date

_____

Child's Name (please print)

Name of medicine, vitamin or herbal How or over-the-counter medicine	much does your child take? (dosage)	How often? (frequency)

_____ _____

Practitioner Signature Date