MEDICATION LIST

Completed By (Name): _____ **Date Completed:** _____

Full Name: _____ **Date of Birth:** _____

Relationship to Me: ☐ Parent ☐ Grandparent ☐ Other Relative ☐ Guardian ☐ Other

MEDICATION NAME	DOSE	TIMES PER DAY	INSTRUCTIONS/SIDE EFFECTS

QUESTIONS/COMMENTS FOR DOCTOR

Disclaimer: This sheet is a way to bring all of your child's medications together in one place to organize, keep track of and use to have on hand for all caregivers, for the doctor's visits and more. It is not a substitute for the medical care plan given by your child's professional team members. Please double and even triple check the information you input and make sure to immediately update it each time any information changes. Use multiple sheets as needed if there isn't enough room for all of the medications.