MEDICATIONS

LIST ALL ALLERGIES and the reaction you had (itching, rash, difficulty breathing, ect.)

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LIST ALL MEDICATION YOU ARE TAKING, including eye drops, inhalers, ointments, spays.

NAME OF MEDICATION	DOSAGE (mg, gr, tsp)	NUMBER of tabs per dose	TIME of each dose
EXAMPLE: Pepcid	20 mg	1	9 am, 5 pm

The above information is accurate and complete.

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Print Name Signature Date