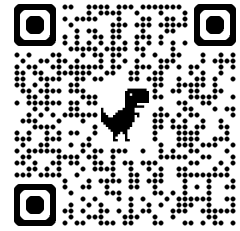




Family Vitals™



## Medication List Template

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### Individual Information

- **Full Name:** \_\_\_\_\_
- **Date of Birth (MM/DD/YYYY):** \_\_\_\_\_
- **Relationship (if child/dependent):** \_\_\_\_\_
- **Primary Care Provider:** \_\_\_\_\_
- **Last Updated (MM/DD/YYYY):** \_\_\_\_\_

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### Emergency Information

- **Emergency Contact Name:** \_\_\_\_\_
- **Phone Number:** \_\_\_\_\_
- **Known Drug Allergies:** ☐ None ☐ Yes (list below)

### Allergy Details (Medication & Reaction):

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### Current Medications

Include all medications taken regularly or as needed (PRN), including prescriptions, over-the-counter drugs, vitamins, and supplements.

Medication Name	Strength / Dose	Route (Oral, Inhaled, Topical, Injection)	Frequency / Timing	Reason / Condition	PRN (As Needed)
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

## Medications Taken at School / Daycare / Camp (If Applicable)

Some institutions require separate authorization forms. This section is for reference only.

Medication	Dose	Time(s) Given	Self-Carry Allowed?	Stored With (Nurse/Staff)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

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## Emergency & Rescue Medications

- ☐ Epinephrine Auto-Injector (EpiPen)
- ☐ Inhaler (Albuterol or equivalent)
- ☐ Glucagon
- ☐ Seizure Rescue Medication

### Medication Name(s) & Instructions:

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**Where medication is kept:** ☐ With individual ☐ Nurse ☐ Staff ☐ Backpack

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## Discontinued or Past Medications (Optional)

Helps providers understand medication history and adverse reactions.

Medication Name	Reason Stopped	Approx. Stop Date	Side Effects / Issues
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## Pharmacy Information

- **Preferred Pharmacy:** \_\_\_\_\_
- **Phone Number:** \_\_\_\_\_

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## Additional Notes

Include administration instructions, food interactions, monitoring needs, or special handling instructions.

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## Acknowledgment

I confirm that the information listed above is accurate to the best of my knowledge and will be updated whenever medications change.

- **Name:** \_\_\_\_\_
  - **Signature:** \_\_\_\_\_
  - **Date:** \_\_\_\_\_
- 

**Clinical & Privacy Note:** Maintaining an up-to-date medication list is a recognized patient safety best practice endorsed by healthcare providers. This document may be shared with schools, caregivers, or medical professionals as needed and should be stored securely.