

Current Medication List (to be completed upon admission/discharge)

Include prescriptions, over the counter, home remedies, herbal remedies, etc.

Medication	Dose	Frequency	Indication for use	Last Dose	Prescribed by	Left at home	Number sent to pharmacy	Number sent home (initialed by receiver)	Prescription sent home	Prescription called into pharmacy name and number

Medication Allergies: _____

I authorize _____ to continue to administer the above listed medication as currently prescribed.
 I request additional information on the above medications. Yes _____ no _____ (please initial)

 Parent or authorized legal guardian

 date

 Witness signature

 date

Patient Name:
 Date: