Medication List at Time of Admission

(Please include all prescription drugs, herbal products, dietary supplements and over-the-counter medications.)

Known Allergies: ______________________________

☐ No medications prior to admission

Drug (generic name preferred)	Dose	Route (by mouth, rectal, etc.)	Frequency (how often, what times)	Time of Last Dose	Comments (special instructions or special times)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

Sources of Information (Parent; outside pharmacy; other facility records; other): ______________________________

Person(s) Providing/Gathering Medication History: ______________________ Date: __________ Time: __________

______________________ Date: __________ Time: __________