Medication Form

Name:____ Date Completed:____________________________
Address:______________________________ City:________________ State: ________ Zip: ______________
Phone Number:___________________________________ Birth Date:________________________________
Emergency Contact/ Phone:____
E-Mail ____
(Notification of sales, specials, and new products and services will be sent by e-mail.)

Allergies and Drugs to Avoid/Adverse Reactions:
____
____

Please list any other special dietary information, or foods you can or will not eat. (ex: vegan, vegetarian, etc.)
____
____
____

Current Medications:

List all medications you are taking, include over-the-counter (e.g. supplements, prescriptions, aspirin, antacids.)

Medication:____ Dosage:________________________
Reason for Taking:_________________________________ Directions:_____________________________
Date Started:_______________________________ Date Discontinued:_____________________________

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Immunization Record:
(Include dates administered)
☐ Tetanus______________ ☐ Pneumonia Vaccine_______________ ☐ Flu Vaccine____________________
☐ Hepatitis Vaccine__________________ ☐ Other____

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