My Medication List
Keep this medication list with you at all times.
Please share it with us at every visit.

Children's Specialized Hospital®
An RWJBarnabas Health facility

Child's Information	Allergies to Medicines	
Name:	Allergic To	Describe Reaction
Address:		
Birth Date:		

Primary Care Physician:	Name:	Phone #:
Preferred Pharmacy:	Address:	Phone #:

List all medications your child is currently taking: Prescription and over-the-counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers).

Prescription Medication Name	Dose (How much)	Frequency (How often)

Over-the-Counter Medication/Vitamins/Herbal Name	Dose (How much)	Frequency (How often)

Medication List Completed or Updated (Date): _____

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