Name: ____ Date of Birth: ______________________

Scheduled Medications:

Name of Medication	Dosage	Instructions	Dosing schedule – Please indicate how many tablets to administer at each of the following times			
			Breakfast	Lunch	Dinner	Bedtime

What is the medication for? ____

Are there any side effects to monitor? ____

Some nights, the retreatants stay up past midnight. Are there any special instructions for bedtime dosing?

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Some nights, the retreatants stay up past midnight. Are there any special instructions for bedtime dosing?

As needed medications:

Name of Medication	Dosage	Instructions	When and how often can the medication be administered?

What is the medication for? ____

Are there any side effects to monitor? ____

Name of Medication	Dosage	Instructions	When and how often can the medication be administered?

What is the medication for? ____

Are there any side effects to monitor? ____

Name: _______________________________________ Date of Birth: ______________________

Allergies:

Insects: ❑ Bee ❑Ant ❑Other ________________

Reaction: ____

How should we respond? ____

Food: _______________________________________

Reaction: ____

How should we respond? ____

Other: ______________________________________

Reaction: ____

How should we respond? ____

Asthma Inhalers:

Name of Medication	Puffs	Special instructions	Directions for medication
Controller medication:			
Rescue Medication (For symptoms):			

What are the asthma triggers?

If the retreatant has been hospitalized for asthma or has used oral steroids in the past 2 years, please discuss the asthma care plan with the director.

EpiPen:

Indications to use EpiPen: ____

Last time EpiPen used: ____

Special precaustions to prevent severe allergic reaction: ____

*****PLEASE FILL OUT BOTH SIDES OF THE FORM*****