PEDIATRIC MEDICAL BACKGROUND

Name of child: _____ Date: _____

Please list all CURRENT MEDICATIONS, include dosage and frequency.

Medication Name	Dosage (amt. in milligrams)	Frequency (how many time in a day)	When was medication started?
1.			
2.			
3.			

Please list all ALLERGIES to medications.

Medication	What happened when medication was taken?
1.	
2.	
3.	

Please list all PAST and CURRENT MEDICAL PROBLEMS, including allergies.

Medical Problem/Hospitalization	Date	Medical Problem/Hospitalization	Date
1.		4.	
2.		5.	
3.		6.	

Emergency Contact Information

Name: _____ Relationship to child: _____

Phone: _____

Child's Physician who may be contacted:

Name: _____ Phone: _____

Specify special considerations such as diet, housing or allergy precautions required:

_____

_____

_____

HARNESS HORSE YOUTH FOUNDATION

Parent or Guardian Signature:

_____