McLAREN MEDICAL GROUP

MEDICATION LIST

Name of Pharmacy:	Telephone:	Name of Pharmacy:	Telephone:
1.	1.	3.	3.
2.	2.	4.	4.

ALLERGIES/REACTIONS (Drugs, Dyes, Latex, etc.)			ALLERGIES/REACTIONS (Drugs, Dyes, Latex, etc.)		
Date	Allergen	Reaction	Date	Allergen	Reaction

DATE	NAME OF MEDICATION/STRENGTH	FREQUENCY	REFILLS	DATE DC'D	STAFF SIGNATURE

Alternate Contact for Patient:

_____

Telephone: ( ) _____

MEDICATION LIST

Patient Name:

Date of Birth: