McLAREN FLINT

MEDICATION LIST

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

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

Medication Date					
Staff Signature					

Alternate Contact for Patient:

_____

Telephone: (____) _____

Patient Name:

Date of Birth:

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