

# MEDICATION FORM

List all medication currently used. Include any occasionally used medication such as inhalers or EpiPens.

Participants Name \_\_\_\_\_ Expedition # \_\_\_\_\_

Medication: \_\_\_\_\_  
Strength: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Reason for taking this medication: \_\_\_\_\_  
\_\_\_\_\_  
Approximate Date Started: \_\_\_\_\_  
Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
Side Effects \_\_\_\_\_  
\_\_\_\_\_  
Storage Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_  
Name of Prescribing Physician \_\_\_\_\_  
Physician's Phone # \_\_\_\_\_

Medication: \_\_\_\_\_  
Strength: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Reason for taking this medication: \_\_\_\_\_  
\_\_\_\_\_  
Approximate Date Started: \_\_\_\_\_  
Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
Side Effects \_\_\_\_\_  
\_\_\_\_\_  
Storage Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_  
Name of Prescribing Physician \_\_\_\_\_  
Phone # \_\_\_\_\_

Medication: \_\_\_\_\_  
Strength: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Reason for taking this medication: \_\_\_\_\_  
\_\_\_\_\_  
Approximate Date Started: \_\_\_\_\_  
Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
Side Effects \_\_\_\_\_  
\_\_\_\_\_  
Storage Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_  
Name of Prescribing Physician \_\_\_\_\_  
Physician's Phone # \_\_\_\_\_

Medication: \_\_\_\_\_  
Strength: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Reason for taking this medication: \_\_\_\_\_  
\_\_\_\_\_  
Approximate Date Started: \_\_\_\_\_  
Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
Side Effects \_\_\_\_\_  
\_\_\_\_\_  
Storage Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_  
Name of Prescribing Physician \_\_\_\_\_  
Physician's Phone # \_\_\_\_\_

Medication: \_\_\_\_\_  
Strength: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Reason for taking this medication: \_\_\_\_\_  
\_\_\_\_\_  
Approximate Date Started: \_\_\_\_\_  
Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
Side Effects \_\_\_\_\_  
\_\_\_\_\_  
Storage Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_  
Name of Prescribing Physician \_\_\_\_\_  
Physician's Phone # \_\_\_\_\_

Medication: \_\_\_\_\_  
Strength: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Reason for taking this medication: \_\_\_\_\_  
\_\_\_\_\_  
Approximate Date Started: \_\_\_\_\_  
Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
Side Effects \_\_\_\_\_  
\_\_\_\_\_  
Storage Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_  
Name of Prescribing Physician \_\_\_\_\_  
Physician's Phone # \_\_\_\_\_