

# EXTENDED MEDICATION INFORMATION

**\*Please include a current sports physical formed filled out by your doctor and copy of your insurance information.**

**Have you had current tetanus shot? YES NO**

**Date (MM,YYYY) \_\_\_\_/\_\_\_\_**

## **Medications:**

All medications will be held by our leaders, then self-administered by the participant. Exceptions are made for asthma, epi-pens, and on a case-by-case basis.

Please describe any recent changes (additions, dose changes, etc.) to the participant's medications:

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Please list all prescription and over-the-counter medications the participant is currently taking:

### **Medication (1):**

Dosage: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Time(s) administered each day: \_\_\_\_\_

When it was prescribed: \_\_\_\_\_

Taking for what condition: \_\_\_\_\_

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### **Medication (2):**

Dosage: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Time(s) administered each day: \_\_\_\_\_

When it was prescribed: \_\_\_\_\_

Taking for what condition: \_\_\_\_\_

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### **Medication (3):**

Dosage: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Time(s) administered each day: \_\_\_\_\_

When it was prescribed: \_\_\_\_\_

Taking for what condition: \_\_\_\_\_

**NAME: \_\_\_\_\_**