



**Children's Specialty Services  
Medical Information Form**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please list all medications your child is currently taking.

Date	Medication	Dosage	Route	Frequency	Needs to take while at program?	Comments

Medication Allergies: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Latex Allergy: \_\_\_\_\_ Other: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_