Medication Tolerance Checklist

CHILD'S NAME: _____ BIRTH DATE: _____
Medications: _____ Dose _____ Times Given: _____
_____ Dose _____ Times Given: _____
_____ Dose _____ Times Given: _____

Name of Prescribing Doctor: _____ Phone: _____

WHICH OF THESE SYMPTOMS DOES YOUR CHILD SHOW? (Check all that apply)

1. _____ Runs about uncontrollably at home in the morning
2. _____ Runs about uncontrollably at home in the afternoon
3. _____ Runs about uncontrollably at home in the evening
4. _____ Appears to be in a fog or dazed in the morning
5. _____ Appears to be in a fog or dazed in the afternoon
6. _____ Appears to be in a fog or dazed in the evening
7. _____ Seems more likely to cry than usual
8. _____ Seems more likely to throw objects, yell at, or hit people than usual
9. _____ Has little or no appetite
10. _____ Is having more difficulty falling asleep at night
11. _____ Has stomach pain or discomfort
12. _____ Has headaches
13. _____ Is drowsy during the day
14. _____ Complains of a dry mouth
15. _____ Is wetting the bed at night
16. _____ Has begun to show a lot of eye blinks, muscle spasms, or shrugs

Other concerns? _____
_____
_____

Please complete this form daily for 5 days. Fax to _____ at the following number _____. Thank you