ASP ADDITIONAL MEDICAL INFORMATION

NAME: _____ DATE OF BIRTH: _____

ALLERGIES: _____

HEALTH PROBLEMS? _____ NONE (Healthy) _____ YES (list below)

_____

_____

ANY PROBLEMS THAT MAY RESULT IN EMERGENCY? _____ NO _____ YES (list below)

_____

_____

MENTAL HEALTH CONCERNS? _____ NO _____ YES (list below)

_____

_____

Is there any other information about your youth you would like to share?

_____

_____

LIST OF CURRENT MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (e.g. albuterol).

Medication Name	Dose	In What Way and How Often You Take the Medication	Reason for Taking

Additional medications may be listed on the back of this form.