temple church

Tanzania Mission Trip July 2024

Name: _____

Date of Birth: _____

MEDICATIONS

Please provide the information requested below for every prescription medication, over-thecounter medication, vitamins or any supplement you are currently taking. The required information can be found on the label printed on the medication bottle. If needed, please use the second page of this form.

Name of medication, indicate if pills, ointment, drops, etc. **Example** Hydrochlorothiazide	Dose each time i.e. mg., drops, tsp., etc. **Example** 25 mg.	How many do you take at a time? **Example** 1	How often do you take this medication? **Example** Once each day	What medical condition is this medication prescribed? **Example** Hypertension

Allergies

Please list any allergies or adverse reactions you have had (Food, medication, or substance)

Medication or substance?	Reaction you experience?	Medication to Counteract? Example – EpiPen

* This information will be kept confidential and only those who are a need-to-know basis will have access. This form will be destroyed immediately following our return from Africa.