

University of Rochester
UNIVERSITY HEALTH SERVICE
 Box 270617
 Rochester, NY 14627-0617
 (585) 275-2662

Name: _____
 Date of Birth: _____
 Student ID #: _____

ALLERGY & MEDICATION LIST

ALLERGY INFORMATION

No Known Allergies

Medication / Substance	Type of Reaction
<i>Example: Penicillin</i>	<i>Example: Severe – Anaphylactic Reaction</i>

CURRENT MEDICATION INFORMATION

(Include ALL medicines taken, i.e., prescription, nonprescription, vitamins, and herbals)

Medicines: Name & Strength	Dose / Frequency	Purpose of Medicine	Name of Prescriber (When applicable)	Start Date
<i>Example: Tetracycline 500 mg</i>	<i>1 Pill / Once a day</i>	<i>Acne</i>	<i>Dr. Jones</i>	<i>8/06/08</i>

(USE BACK OF SHEET IF NEEDED)

