Allegro PEDIATRICS

Physical/Medication Form Completion Request

Patient Name: _____ Patient Date of Birth:_____

Parent/guardian section filled out on physical or medication form: ☐ Yes (if no, please complete)

Would you like to (check one):

- ☐ Pick up form (include # to call when ready for pick-up): _____
- ☐ Receive form by fax (include fax #): _____
- ☐ Receive form by postal mail in 1-2 weeks (e-mail not available, include mailing address on line below):

_____

Street Address City State Zip

Comments? _____

For medication authorization forms, please also fill out the section below:

Medication Name: _____ Circle one: Pill / Liquid / Chewable / Other

Current weight (if known): _____ Reason for medication: _____

Strength of medication (e.g., "mg each" or "mg per ml"): _____

Dose (leave blank if unknown): _____

Has patient been taught to self-carry and self-administer this medication? Yes / No

Medication refill needed? Yes / No If Yes, what is your preferred pharmacy? _____

Medication Name: _____ Circle one: Pill / Liquid / Chewable / Other

Current weight (if known): _____ Reason for medication: _____

Strength of medication (e.g., "mg each" or "mg per ml"): _____

Dose (leave blank if unknown): _____

Has patient been taught to self-carry and self-administer this medication? Yes / No

Medication refill needed? Yes / No If Yes, what is your preferred pharmacy? _____

For additional medications, use the back of this form.

********** **Office Use Only** **********

Patient account #: _____ Today's date: _____ (Due back w/in 48 hrs.)

Date of last WCC: _____

Preferred Provider (or last WCC provider): _____

Assigned to:_____ Circle: PCP / Practice Partner / Other

Additional Medications:

Medication Name: ___________________________________ Circle one: Pill / Liquid / Chewable / Other

Current weight (if known): _____________ Reason for medication: ________________________________

Strength of medication (e.g., "mg each" or "mg per ml"): ____

Dose (leave blank if unknown): _____________________

Has patient been taught to self-carry and self-administer this medication? Yes / No

Medication refill needed? Yes / No If Yes, what is your preferred pharmacy? _____________________

Medication Name: ___________________________________ Circle one: Pill / Liquid / Chewable / Other

Current weight (if known): _____________ Reason for medication: ________________________________

Strength of medication (e.g., "mg each" or "mg per ml"): ____

Dose (leave blank if unknown): _____________________

Has patient been taught to self-carry and self-administer this medication? Yes / No

Medication refill needed? Yes / No If Yes, what is your preferred pharmacy? _____________________

Medication Name: ___________________________________ Circle one: Pill / Liquid / Chewable / Other

Current weight (if known): _____________ Reason for medication: ________________________________

Strength of medication (e.g., "mg each" or "mg per ml"): ____

Dose (leave blank if unknown): _____________________

Has patient been taught to self-carry and self-administer this medication? Yes / No

Medication refill needed? Yes / No If Yes, what is your preferred pharmacy? _____________________

Medication Name: ___________________________________ Circle one: Pill / Liquid / Chewable / Other

Current weight (if known): _____________ Reason for medication: ________________________________

Strength of medication (e.g., "mg each" or "mg per ml"): ____

Dose (leave blank if unknown): _____________________

Has patient been taught to self-carry and self-administer this medication? Yes / No

Medication refill needed? Yes / No If Yes, what is your preferred pharmacy? _____________________