Medication Information Form
for Safety Policy on Drugs & Alcohol

Name_____ SS#_____

Address_____ Position_____

_____ Work Location_____

_____ Home Phone_____

Name of Medication_____

Dosage_____

Prescribing Physician:Name _____

Address _____

Telephone _____ Date Prescribed_____

Condition for which medication is taken_____

_____

List possible side effects of medication_____

_____

How long do you expect to take this medication?_____

Family physician, if other than above_____

I am taking the medication listed above for the condition described. I accept responsibility for the possession and use of this medication in a safe manner.

I hereby give my consent for the above-named physician to answer any questions about my use of the above-named medication.

_____ _____

Employee Signature Date

_____ _____

Director of Safety Signature Date