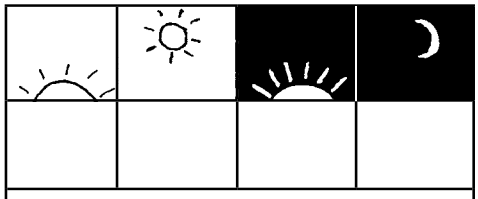
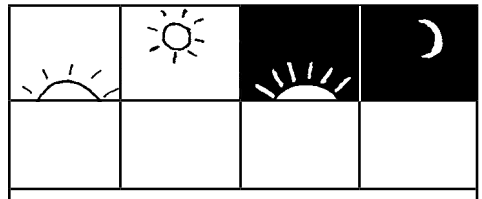
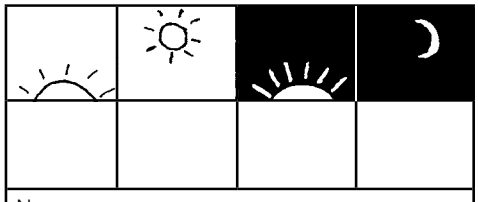
DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)



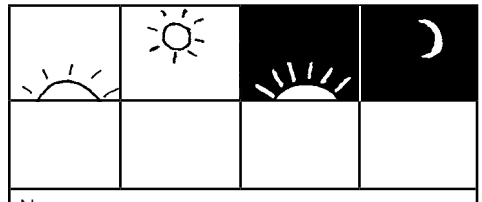
Name:
Medicine:
For:
Dosage:



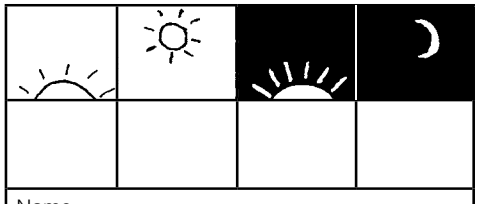
Name:
Medicine:
For:
Dosage:



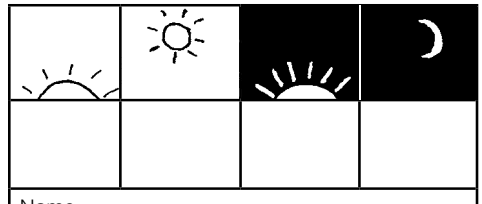
Name:
Medicine:
For:
Dosage:



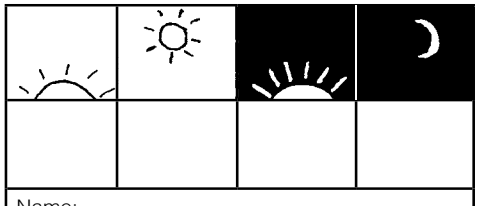
Name:
Medicine:
For:
Dosage:



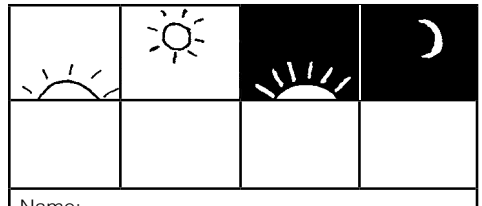
Name:
Medicine:
For:
Dosage:



Name:
Medicine:
For:
Dosage:

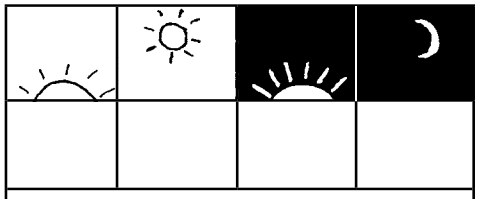


Name:
Medicine:
For:
Dosage:

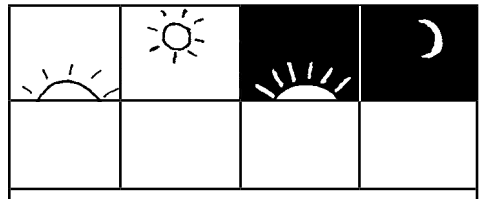


Name:
Medicine:
For:
Dosage:

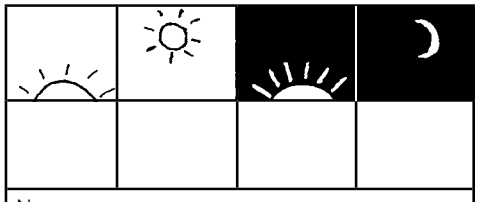
DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)



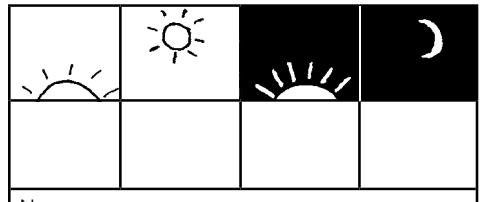
Name:
Medicine:
For:
Dosage:



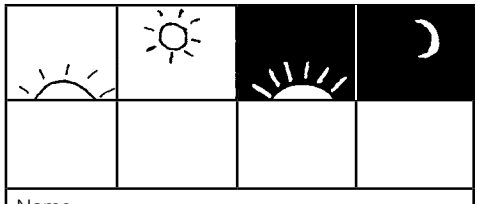
Name:
Medicine:
For:
Dosage:



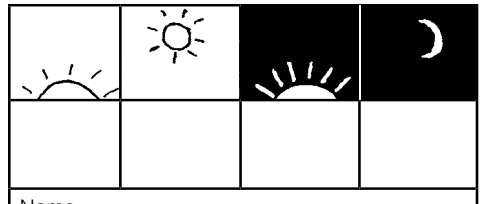
Name:
Medicine:
For:
Dosage:



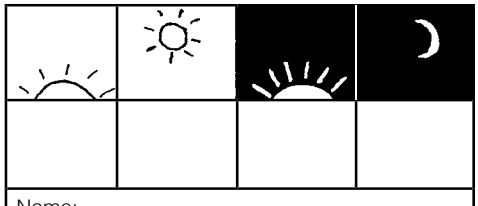
Name:
Medicine:
For:
Dosage:



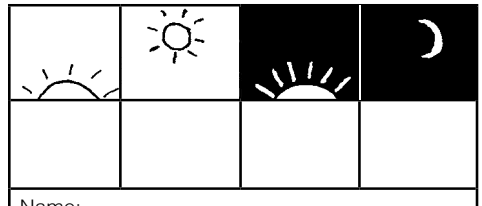
Name:
Medicine:
For:
Dosage:



Name:
Medicine:
For:
Dosage:

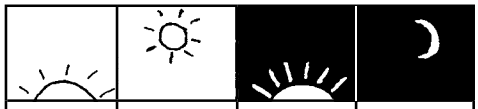


Name:
Medicine:
For:
Dosage:

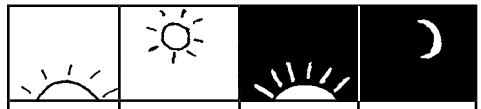


Name:
Medicine:
For:
Dosage:

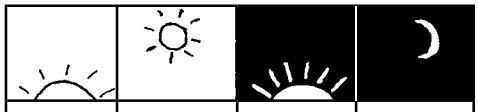
DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)



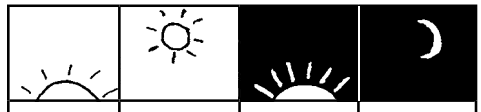
Name:
Medicine:
For:
Dosage:



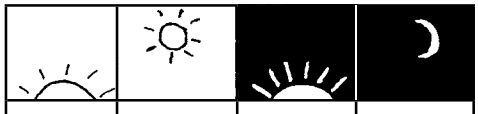
Name:
Medicine:
For:
Dosage:



Name:
Medicine:
For:
Dosage:

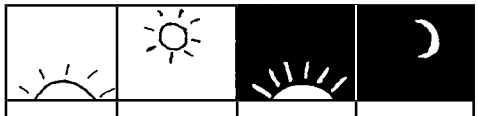


Name:
Medicine:
For:
Dosage:



Name:
Medicine:
For:
Dosage:

Name:
Medicine:
For:
Dosage:



Name:
Medicine:
For:
Dosage:

Name:
Medicine:
For:
Dosage:

PATIENT REPORT

TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person: _____Age: _____

Male _____ Female_____ Where is he (she)? _____

What is the main sickness or problem right now?_____

_____

_____

_____

When did it begin? _____

How did it begin? _____

Has the person had the same problem before? _____When? _____

Is there fever? _____ How high? _____° When and for how long? _____

Pain? _____Where?_____What kind?_____

What is wrong or different from normal in any of the following?

Skin:_____ **Ears:**_____

Eyes: _____ **Mouth and throat:** _____

Genitals: _____

Urine: Much or little? _____Color?_____Trouble urinating?_____

Describe: _____Times in 24 hours: _____ Times at night: ____

Stools: Color?_____ Blood or mucus?_____ Diarrhea? _____

Number of times a day: _____Cramps? _____ Dehydration?_____Mild or severe?_____ Worms? _____What kind? _____

Breathing: Breaths per minute:_____ Deep, shallow, or normal? _____

Difficulty breathing (describe):_____ Cough (describe):_____

_____Wheezing?_____ Mucus?_____ With blood?_____

Does the person have any of the SIGNS OF DANGEROUS ILLNESS listed on page 42? _____Which? (give details)_____

_____

Other signs: _____

Is the person taking medicine? _____What?_____

Has the person ever used medicine that has caused a rash, hives (or bumps) with itching, or other allergic reactions?_____ What?_____

The state of the sick person is: Not very serious: _____Serious: _____

Very serious: _____

On the back of this form write any other information you think may be important.

PATIENT REPORT

TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person: _____ Age: ____

Male _____Female_____ Where is he (she)?_____

What is the main sickness or problem right now?_____

_____

_____

_____

When did it begin? _____

How did it begin? _____

Has the person had the same problem before? _____ When?_____

Is there fever? _____How high? _____ ° When and for how long?_____

Pain? _____Where?_____What kind? _____

What is wrong or different from normal in any of the following?

Skin:_____ **Ears:**_____

Eyes: _____ **Mouth and throat:**_____

Genitals: _____

Urine: Much or little? _____ Color? _____ Trouble urinating? ____

Describe: _____Times in 24 hours: _____Times at night: ___

Stools: Color?_____Blood or mucus? _____Diarrhea?_____

Number of times a day: _____ Cramps? _____Dehydration? _____ Mild or severe?_____ Worms?_____ What kind?_____

Breathing: Breaths per minute:_____ Deep, shallow, or normal?_____

Difficulty breathing (describe):_____Cough (describe): _____

_____Wheezing?_____Mucus? _____With blood? ____

Does the person have any of the SIGNS OF DANGEROUS ILLNESS listed on page 42? _____Which? (give details)_____

_____

Other signs: _____

Is the person taking medicine? _____ What? _____

Has the person ever used medicine that has caused a rash, hives (or bumps) with itching, or other allergic reactions?_____What? _____

The state of the sick person is: Not very serious: _____Serious: _____

Very serious: _____

On the back of this form write any other information you think may be important.

PATIENT REPORT

TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person: _____Age: _____

Male ____ Female_____ Where is he (she)? _____

What is the main sickness or problem right now?_____

_____

_____

_____

When did it begin? _____

How did it begin? _____

Has the person had the same problem before? _____ When?_____

Is there fever? _____ How high? _____ ° When and for how long?_____

Pain? _____ Where? _____What kind? _____

What is wrong or different from normal in any of the following?

Skin:_____ **Ears:**_____

Eyes: _____ **Mouth and throat:**_____

Genitals: _____

Urine: Much or little? _____ Color? _____Trouble urinating? _____

Describe: _____ Times in 24 hours:_____Times at night: ____

Stools: Color? _____ Blood or mucus? _____Diarrhea?_____

Number of times a day: _____Cramps? _____Dehydration?_____Mild or severe?_____ Worms? _____What kind?_____

Breathing: Breaths per minute:_____Deep, shallow, or normal? _____

Difficulty breathing (describe):_____Cough (describe): _____

_____Wheezing? _____ Mucus?_____With blood? _____

Does the person have any of the SIGNS OF DANGEROUS ILLNESS listed on page 42? _____ Which? (give details) _____

_____

Other signs: _____

Is the person taking medicine? _____What?_____

Has the person ever used medicine that has caused a rash, hives (or bumps) with itching, or other allergic reactions?_____ What?_____

The state of the sick person is: Not very serious: _____ Serious:_____

Very serious: _____

On the back of this form write any other information you think may be important.

PATIENT REPORT

TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person: _____Age: _____

Male ____ Female _____ Where is he (she)? _____

What is the main sickness or problem right now?_____

_____

_____

_____

When did it begin? _____

How did it begin? _____

Has the person had the same problem before? _____When? _____

Is there fever? _____How high? _____ ° When and for how long?_____

Pain? _____ Where? _____ What kind? _____

What is wrong or different from normal in any of the following?

Skin:_____ **Ears:**_____

Eyes: _____**Mouth and throat:** _____

Genitals: _____

Urine: Much or little? _____ Color? _____ Trouble urinating?_____

Describe: _____Times in 24 hours: _____ Times at night: _____

Stools: Color?_____ Blood or mucus?_____ Diarrhea?_____

Number of times a day: _____ Cramps? _____Dehydration?_____Mild or severe?_____ Worms?_____ What kind? _____

Breathing: Breaths per minute:_____ Deep, shallow, or normal?_____

Difficulty breathing (describe):_____Cough (describe): _____

_____ Wheezing? _____Mucus?_____With blood? _____

Does the person have any of the SIGNS OF DANGEROUS ILLNESS listed on page 42? _____ Which? (give details) _____

_____

Other signs: _____

Is the person taking medicine? _____ What? _____

Has the person ever used medicine that has caused a rash, hives (or bumps) with itching, or other allergic reactions?_____What? _____

The state of the sick person is: Not very serious: _____ Serious:_____

Very serious: _____