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

DOSAGE BEANNS—TOT GIVING MEDICINE	
Name:	Name:
Medicine:	Medicine:
For:	For:
Dosage:	Dosage:
Name:	Name:
Medicine:	Medicine:
For:	For:
Dosage:	Dosage:
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Name: Medicine:	Name: Medicine:
Name: Medicine: For:	Name:
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DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)

DOSAGE BEANNS—TOT GIVING MEDICINE	
Name:	Name:
Medicine:	Medicine:
For:	For:
Dosage:	Dosage:
Name:	Name:
Medicine:	Medicine:
For:	For:
Dosage:	Dosage:
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DUSAGE	BLAINKS-	—for giving	medicines	to those wh	io cannot	read (see p). 64)
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Name:				Name:			
Medicine:				Medicine:			
For:				For:			
Dosage:		1		Dosage:			
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Medicine:				Medicine:			
For:				For:			
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Name:				Name:			
Medicine:				Medicine:			
For:				For:			
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Name:				Name:			
Medicine:				Medicine:			
For:				For:			
Dosage:				Dosage:			

TO USE WHEN SENDING FOR MEDICAL HELP

Name of t	the sick person:				_Age:
Male	Female	Where is	he (she)?		
What is th	ne main sickness	or problem r	ight now?		
When did	it begin?				
How did i	t begin?				
Has the p	erson had the sa	ame problem	before?	When?	
Is there fe	ever? F	low high?	° When a	nd for how long?	
				at kind?	
	1144				
What is v	vrong or differe	nt from norn	nal in any of the	following?	
Skin:			Ears:		
Eyes:			Mouth and thr	oat:	
Genitals:					
Urine: Mu	uch or little?		Color?	Trouble urir	nating?
Describe:	:	T	imes in 24 hours	s: Times a	nt night:
Stools: C	color?	Blood	d or mucus?	Diarr	hea?
Number of	of times a day: _	Cran	nps? [Dehydration?	Mild o
severe?_		Worms?	What kind	i?	
Breathing	g: Breaths per m	ninute:	Deep, sha	llow, or normal?_	
Difficulty	breathing (descr	ibe):		Cough (descr	ibe):
	Wr	neezing?	Mucus?_	With I	blood?
Does the	person have a	ny of the SIG	NS OF DANGE	ROUS ILLNESS I	isted on
page 42?	Whi	ch? (give det	ails)		
Other sig	ıns:				
-		cine?	What?		
Has the p	erson ever used	medicine that	at has caused a	rash, hives (or bu	mps)
•				nat?	• •
The state	of the sick person	on is: Not ver	y serious:	Seriou	JS:
	ous:				

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

TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person:		Age:
MaleFemale	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	•	
Is there fever?How	-	_
Pain?Where?	What I	kind?
What is wrong or different f	rom normal in any of the fo	ollowing?
Skin:	Ears:	
Eyes:	Mouth and throa	at:
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? De	hydration? Mild c
severe? Wo	rms? What kind?	
Breathing: Breaths per minut	te: Deep, shallo	ow, or normal?
Difficulty breathing (describe)):	_Cough (describe):
Whee	ezing?Mucus?	With blood?
Does the person have any o		
page 42?Which?	(give details)	
Other signs:		
Is the person taking medicine	e? What?	
Has the person ever used me	edicine that has caused a ra	sh, hives (or bumps)
with itching, or other allergic i	reactions?Wha	it?
The state of the sick person is	s: Not very serious:	Serious:
Very serious:		

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

TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick pers	on:			Ag	ge:
MaleFemale	Where is h	ie (she)?			
What is the main sickr	ess or problem	right now?_			
When did it begin?					
How did it begin?					
Has the person had th	e same proble	m before?	Whe	n?	
Is there fever?	How high?	° Wher	n and for how	v long?	
Pain? Where?		\	What kind? _		
What is wrong or diff	erent from no	rmal in any o	of the follow	ring?	
Skin:		_Ears:			
Eyes:		Mouth and	throat:		
Genitals:					
Urine: Much or little?	(Color?	Tro	uble urinatii	ng?
Describe:	T	imes in 24 ho	ours:	_Times at r	night:
Stools: Color?	Blood	or mucus?_		Diarrhe	a?
Number of times a day	/:Cram	nps?	Dehydrati	on?	Mild or
severe?	Worms?	What k	kind?		
Breathing: Breaths pe	er minute:	Deep, s	shallow, or no	ormal?	
Difficulty breathing (de	escribe):		Cough	n (describe)	:
V	/heezing?	Mucu	s?	With blo	od?
Does the person hav	e any of the SI	GNS OF DA	NGEROUS	ILLNESS lis	ted on
page 42? Wh	ich? (give deta	ils)		 	
Other signs:					
Is the person taking m					
Has the person ever u					
with itching, or other a					
The state of the sick p	o .				
Very serious:		,			

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

TO USE WHEN SENDING FOR MEDICAL HELP

Name of	the sick person: _		Age:
Male	Female\	Where is he (she)?	
What is th	ne main sickness c	or problem right now?	
When dic	d it begin?		
How did	it begin?		
Has the p	person had the san	ne problem before?	When?
Is there for	ever?How	high? ° When ar	nd for how long?
Pain?	Where?	Wh	at kind?
What is v	wrong or different	t from normal in any of t	he following?
Skin:		Ears:	
Eves:		Mouth and the	roat:
-			
			Trouble urinating?
			s: Times at night:
			 Diarrhea?
			Dehydration?Mild or
			d?
Breathin	g: Breaths per min	nute: Deep, sha	allow, or normal?
			Cough (describe):
	Wheez	zing?Mucus?_	With blood?
Does the	person have any	of the SIGNS OF DANG	EROUS ILLNESS listed on
page 42?	? Which?	(give details)	
Other sig	gns:		
Is the per	rson taking medicii	ne? What?	
Has the p	oerson ever used n	nedicine that has caused	a rash, hives (or bumps)
with itchir	ng, or other allergio	c reactions?W	hat?
The state	of the sick person	is: Not very serious:	Serious:
Very serio	ous:		

