DOSAGE BLANK	(S—for giving me	dicines to	those wh	o cannot	read (see p	o. 64)	
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Medicine:			Medicine:				
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DOSAGE BLANK	(S—for giving me	dicines to	those wh	o cannot	read (see p	o. 64)	
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Medicine:			Medicine:				
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DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)

Name:	Name:				
Medicine:	Medicine:				
For:	For:				
Dosage:	Dosage:				
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TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person: _				Age:
MaleFemale	_ Where is he	e (she)?		
What is the main sickness	or problem rig	ht now?		
When did it begin?				
How did it begin?				
Has the person had the sai				
Is there fever? Ho	ow high?	° When a	and for how long?	
Pain?Where?		Wh	nat kind?	
What is wrong or differen	t from norma	I in any of th	e following?	
Skin:		-		
JKIII.		Lais		
Eyes:	I	Mouth and th	ıroat:	
Genitals:				
Urine: Much or little?	Cc	olor?	Trouble uri	nating?
Describe:	Tim	nes in 24 hour	rs: Times	at night:
Stools: Color?	Blood o	or mucus?	Diar	rhea?
Number of times a day:	Cramp	os?	Dehydration?	Mild o
severe?W	/orms?	What kin	nd?	
Breathing: Breaths per min	nute:	Deep, sh	allow, or normal?_	
Difficulty breathing (describ	oe):		Cough (desc	ribe):
Whe	ezing?	Mucus?	With	blood?
Does the person have any	-			
page 42?Whic	h? (give detail	s)		
Other signs:				
Is the person taking medic	ine?	What?		
Has the person ever used i	medicine that	has caused a	a rash, hives (or b	umps)
with itching, or other allergi	c reactions?_	W	/hat?	
The state of the sick person	n is: Not very s	serious:	Seric	ous:
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:
MaleFemale	Where is he (she)?	
What is the main sickness or p	problem right now?	
When did it hadin?		
When did it begin? How did it begin?		
Has the person had the same		
Is there fever?How		
Pain?Where?	_	_
raiii:willele:	vviiat r	MIIU!
What is wrong or different for	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? Wor	rms? What kind?	
Breathing: Breaths per minut	e: Deep, shallo	w, 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 ras	sh, hives (or bumps)
with itching, or other allergic r	reactions?Wha	t?
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 per	son:				.Age:
MaleFemale	Where	is he (she)?			
What is the main sick	ness or prob	lem right now?_			
<u> </u>					
When did it begin?_					
How did it begin?					
Has the person had	the same prol	blem before?	W	/hen?	
Is there fever?	_ How high?	° Wher	n and for h	now long?	
Pain? Where	!?	\	What kind	?	
What is wrong or di	fferent from	normal in any	of the foll	owing?	
Skin:		Ears:			
Eyes:		Mouth and	throat:		
Genitals:				·····	
Urine: Much or little?				Trouble urin	ating?
Describe:		_ Times in 24 h	ours:	Times a	at night:
Stools: Color?	Blo	ood or mucus?_		Diarr	hea?
Number of times a d	ay:Cı	ramps?	Dehydi	ration?	Mild or
severe?	_ Worms?	What A	kind?		
Breathing: Breaths	oer minute:	Deep, s	shallow, or	normal? _	
Difficulty breathing (d	describe):		Cou	ugh (describ	oe):
	Wheezing? _	Mucu	ıs?	With I	olood?
Does the person ha	ve any of the	SIGNS OF DA	NGEROU	S ILLNESS	listed on
page 42? W	hich? (give d	etails)			
Other signs:					
Is the person taking					
Has the person ever					
with itching, or other				•	• •
The state of the sick	_				
Very serious:		-			<u> </u>

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 per	son:				Age:
Male Female _	Where is	s he (she)?			
What is the main sick	kness or proble	em right now?_			
When did it begin?_					
How did it begin?					
Has the person had	the same prob	lem before?	W	hen?	
Is there fever?	How high?_	° Wher	n and for h	ow long?	
Pain? Wher	e?		What kind	?	
What is wrong or di	ifferent from n	normal in any o	of the follo	owing?	
Skin:		Ears:			
Eyes:		Mouth and	throat: _		
Genitals:					
Urine: Much or little?	?	_ Color?		Trouble urin	ating?
Describe:		_Times in 24 h	ours:	Times at	night:
Stools: Color?	Blo	od or mucus?_		Diarrl	nea?
Number of times a d	ay: Cr	amps?	Dehydr	ation?	Mild or
severe?	Worms?	What I	kind?		
Breathing: Breaths	per minute:	Deep,	shallow, o	r normal?	
Difficulty breathing (describe):		Co	ugh (descri	be):
	Wheezing?_	Mucu	s?	With k	olood?
Does the person ha	ve any of the	SIGNS OF DA	NGEROU	S ILLNESS	listed on
page 42? V	Vhich? (give de	etails)			
Other signs:					
Is the person taking	medicine?	What? _			
Has the person ever	used medicine	e that has caus	sed a rash	hives (or b	umps)
with itching, or other	allergic reaction	ons?	_What?		
The state of the sick	person is: Not	very serious: _		Seriou	IS:
Very serious:					

