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:		
	) ji		
Name:	Name:		
Name: Medicine:	Name: Medicine:		
Name: Medicine: For:	Name: Medicine: For:		
Name: Medicine:	Name: Medicine:		
Name: Medicine: For:	Name: Medicine: For:		
Name: Medicine: For:	Name: Medicine: For:		
Name: Medicine: For: Dosage:	Name: Medicine: For: Dosage:		
Name:  Medicine: For: Dosage:	Name:  Medicine:  For:  Dosage:		
Name:  Medicine:  For:  Dosage:  Name:  Medicine:	Name: Medicine: For: Dosage:  Name: Medicine:		
Name:  Medicine: For: Dosage:	Name:  Medicine:  For:  Dosage:		

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:		
	) ji		
Name:	Name:		
Name: Medicine:	Name: Medicine:		
Name: Medicine: For:	Name: Medicine: For:		
Name: Medicine:	Name: Medicine:		
Name: Medicine: For:	Name: Medicine: For:		
Name: Medicine: For:	Name: Medicine: For:		
Name: Medicine: For: Dosage:	Name: Medicine: For: Dosage:		
Name:  Medicine: For: Dosage:	Name:  Medicine:  For:  Dosage:		
Name:  Medicine:  For:  Dosage:  Name:  Medicine:	Name: Medicine: For: Dosage:  Name: Medicine:		
Name:  Medicine: For: Dosage:	Name:  Medicine:  For:  Dosage:		

DUSAGE	BLAINKS-	—for giving	medicines	to those wh	io cannot	read (see p	). 64)
``	;Ò:	1111	)	``	;Ò:	111/	)
Name:				Name:			
Medicine:				Medicine:			
For:				For:			
Dosage:		1		Dosage:			
``	ÿ.	1111/	)	``	ÿ.	111/	)
Name:				Name:			
Medicine:				Medicine:			
For:				For:			
Dosage:				Dosage:			
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Name:				Name:			
Medicine:				Medicine:			
For:				For:			
Dosage:				Dosage:			
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``	;Q:	1111		``	;Q:	1111	)
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	right now?			
When did	it begin?					
How did i	t begin?					
Has the p	erson had the sa	ame problem	before?	V	Vhen?	
Is there fe	ever? F	low high? _	° Wher	n and for	how long? _	
	Where?_					
	1144					
What is v	vrong or differe	nt from norr	nal in any of	the follo	wing?	
Skin:			Ears:			
Eyes:			_ Mouth and	throat: _		
Genitals:						
Urine: Mu	uch or little?		Color?		Trouble urina	ating?
Describe:	:		Times in 24 ho	ours:	Times at	night:
Stools: C	color?	Bloo	d or mucus?_		Diarrh	ea?
Number of	of times a day: _	Cra	mps?	_ Dehyd	ration?	Mild o
severe?_		Worms?	What k	kind?		
Breathing	<b>g:</b> Breaths per m	ninute:	Deep, s	shallow, c	r normal?	
Difficulty	breathing (descr	ibe):		Co	ugh (describ	oe):
	Wh	neezing?	Mucus	s?	With b	lood?
Does the	person have a	ny of the SIG	SNS OF DANG	GEROUS	ILLNESS lis	sted on
page 42?	Whi	ch? (give de	tails)			
Other sig	ıns:					
_	son taking medi	cine?	What?			
Has the p	erson ever used	I medicine th	at has caused	d a rash, l	hives (or bur	nps)
with itchir	ng, or other aller	gic reactions	?	What?	· 	
The state	of the sick person	on is: Not ver	y serious:		Seriou	S:
	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	e problem before?	When?
Is there fever?How	high?° When and	for how long?
Pain?Where?	What k	ind?
What is wrong or different for	rom normal in any of the fo	llowing?
what is wrong or unlerent in	Tom normal in any of the to	nowing:
Skin:	Ears:	
Eyes:	Mouth and throa	ıt:
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? Del	nydration? Mild c
severe? Wor	rms? What kind?	
Breathing: Breaths per minut	te: Deep, shallo	w, or normal?
Difficulty breathing (describe)	):	_Cough (describe):
Whee	ezing?Mucus?	With blood?
Does the person have any o	of the SIGNS OF DANGERO	<b>US ILLNESS</b> listed on
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 p	erson:		Age	:
MaleFemale	Where	is he (she)?		
What is the main s	ickness or prob	lem right now?		
When did it begin?				
How did it begin?				
Has the person ha	d the same pro	blem before?	When?	
Is there fever?	How high?	° When a	and for how long?	
Pain? Whe	ere?	W	nat kind?	
What is wrong or	different from	normal in any of	the following?	
Skin:		Ears:		
Eyes:		Mouth and th	roat:	
Genitals:				
Urine: Much or little	le?	_ Color?	Trouble urinating	y?
Describe:		_ Times in 24 hou	ırs:Times at niç	yht:
Stools: Color?	Blo	ood or mucus?	Diarrhea?	)
Number of times a	day:C	ramps?	_Dehydration?	Mild or
severe?	Worms?	What kin	d?	
Breathing: Breath	s per minute:	Deep, sha	allow, or normal?	
Difficulty breathing	(describe):		Cough (describe):_	
	Wheezing? _	Mucus?	YWith blood	d?
Does the person	have any of the	SIGNS OF DAN	GEROUS ILLNESS liste	ed on
page 42?	Which? (give d	etails)		
Other signs:				
_				
			d a rash, hives (or bump	
			/hat?	
9.	<u> </u>		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 person:		Age:
Male Female W	/here 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	e problem before?	When?
Is there fever?How h	nigh? ° When and f	or how long?
Pain? Where?	What k	kind?
What is wrong or different	from normal in any of the	following?
Skin:	Ears:	
Eyes:	Mouth and throa	t:
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?Deh	nydration?Mild or
severe? Worm	ns? What kind? _	
Breathing: Breaths per minu	ite: Deep, shallow	w, or normal?
Difficulty breathing (describe	9):	_Cough (describe):
Wheezi	ng?Mucus?	With blood?
Does the person have any	of the SIGNS OF DANGER	OUS ILLNESS listed on
page 42? Which? (c	give details)	
Other signs:		
Is the person taking medicine	e? What?	
Has the person ever used me		
with itching, or other allergic		
The state of the sick person i		
Very serious:		

