



Opening Gaits Medication List

Name: _____
 Birth Date: _____
 Phone #: _____

Emergency Contact: _____
 Phone #: _____
 Email: _____

Please always advise the Instructor if the riders medication has been stopped, changed or updated

Reviewed by:

<i>Instructor</i>	<i>Date</i>
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MEDICATION <small>brand, generic name, dose</small>	Dosage	HOW MANY ?	HOW TAKEN ?	STARTED taking on:	STOP taking on:	REASON FOR TAKING	Comments
AS NEEDED							
AFTER WAKING UP							
AFTERNOON							
EVENING							
BEFORE BED							

Any other information