Medication Side Effects Checklist

Child: _____

Medication: _____ Date: _____

The following are some common side effects of medication. Many of these symptoms improve with the passage of time or with a change in dosage. This form, along with the Medication Record form, is helpful to the child's physician in determining if the medication/dosage will be effective or if the symptoms may be related to something else. ***Only the child's physician can determine what is appropriate for the child.*** Rate the presence of each symptom using a new form for each day.

Loss of appetite	None	1	2	3	4	5	Severe
Insomnia	None	1	2	3	4	5	Severe
Sadness	None	1	2	3	4	5	Severe
Depression	None	1	2	3	4	5	Severe
Fearfulness	None	1	2	3	4	5	Severe
Social withdraw	None	1	2	3	4	5	Severe
Sleepiness	None	1	2	3	4	5	Severe
Headaches	None	1	2	3	4	5	Severe
Nail biting	None	1	2	3	4	5	Severe
Stomach upset	None	1	2	3	4	5	Severe
Weight loss	None	1	2	3	4	5	Severe
Irritability	None	1	2	3	4	5	Severe
Tics	None	1	2	3	4	5	Severe
Behavior rebound	None	1	2	3	4	5	Severe

Comments: _____

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