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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