



LACTATION CENTER & MOTHERS' MILK BANK  
 3000 New Bern Ave.  
 Raleigh, NC 27610  
 919 350-8599  
 Fax: 919 350-8923

**ILLNESS and MEDICATION FORM**

**PLEASE COMPLETE THE FOLLOWING INFORMATION AND INCLUDE THIS FORM WITH YOUR SHIPMENT OR DELIVERY OF MILK. PLEASE DATE AND SIGN THE FORM.**

**DONOR #** \_\_\_\_\_ Dates this milk was pumped \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had any illnesses or changes in your health during the time you pumped this milk?  
 YES \_\_\_\_\_ NO \_\_\_\_\_

Date illness began: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date illness ended: \_\_\_\_/\_\_\_\_/\_\_\_\_

Brief description of symptoms: \_\_\_\_\_

Fever: (circle one) YES NO *If so, what was the temperature?* \_\_\_\_\_ °F

Dates of temperature: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you taken any medication during the time you pumped this milk for this illness?  
 YES \_\_\_\_\_ NO \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Date started: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date ended: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has anyone in your household had an illness or change in their health during the time this milk was pumped? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, who? \_\_\_\_\_

Date illness began \_\_\_\_/\_\_\_\_/\_\_\_\_ Date illness ended \_\_\_\_/\_\_\_\_/\_\_\_\_

Fever? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, what was the temperature? \_\_\_\_\_

Brief description of symptoms: \_\_\_\_\_

*(continued on next page)*

