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This is to verify that \_\_\_\_\_

has been NPO (nothing to eat or drink) since,

\_\_\_\_\_ .

Medications taken \_\_\_\_\_

What time were medications taken? \_\_\_\_\_

What were medicatons taken with? \_\_\_\_\_

Allowing this person to eat or drink before anesthesia or said procedure can be life threatening. Please sign below verifying that this policy has been enforced, while this person was in your care. If this form does not accompany patient, appointment will be cancelled and the deposit forfeited.

\_\_\_\_\_  
Signature of overnight staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of morning staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of transporting staff

\_\_\_\_\_  
Date