DRUGSTORE ITEMS

Date_____

Fill in size, brand and amount needed next to each item.
This form can be filled in, saved, edited, and then printed.

ITEM	SIZE/BRAND/FLAVOR
Toothpaste	
Toothbrush	
Dental floss	
Mouthwash	
Deodorant (roll-on or spray)	
Sanitary Napkins	
Tampons	
Shaving Cream	
Razors	
Body Lotion	
Face Cream	
Make-up Remover	
Contact Lens supply (specific brand)	
Cleaner daily	
Cleaner weekly	
Saline	
Eyedrops	
Headache remedy	
Cold remedy	
Cotton balls	
Q-tips	
Nail polish remover	
Shampoo	
Conditioner	
Hair spray	
Other Items:	

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