



Last update_____


Pharmacy & Phone_____

Date of birth_____

Write down all your prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies

Medication name & date started	Dose (Mg, units, drops)	When taken (Daily, at bedtime)	Reason for taking (Blood pressure, diabetes,)	Prescribing health care provider & phone number

Complete this form and keep it in your folder at all times. Keep this list current by updating your medication information often. Place your file in your emergency kit for quick access by first responders and emergency personal. Bring your file with you to any hospital visit or emergency care center.

 Medication list continued on back

Medication name & date started	Dose (Mg, units, drops)	When taken (Daily, at bedtime)	Reason for taking (Blood pressure, diabetes)	Prescribing health care provider & phone number
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