Other Important Information:

What medications should I include?
Prescription medicines
Over-The-Counter medicines
Vitamins
Herbal remedies
Nutrition pills
Respiratory therapy medicines (such as inhalers)
Blood factors (such as Factor VIII)
IV solutions
IV nutrition

Most Recent Adult Immunizations:

Pneumonia: _____

Tetanus: _____

Hepatitis: _____

Flu: _____

_____

Allergies:

Doctors:
Name: _____

Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

Pharmacies:
Name: _____

Phone: _____

Name: _____

Phone: _____

Wallet Medication Card

Name: _____

Phone: _____

Emergency Contact Name:

_____

Emergency Contact Phone:

_____

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----------Fold here first----------

Start date	**Drug Name & (Strength)**	**Dose** (pills, units, puffs, drops)	**When do you take it?** How many times a day? Morning & night? After meals?	**Purpose** Why do you take it?	**Start date**	**Drug Name & (Strength)**	**Dose** (pills, units, puffs, drops)	**When do you take it?** How many times a day? Morning & night? After meals?	**Purpose** Why do you take it?