**Medication List**

My Name: Emergency Contact:

My Birth Date: Phone #:

My Phone #: Email:

My Email:

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| *My Allergies* | |  | |  | |  | |  | |  | | *Name* | | | *Date* |
|  | | | | | | | |  | | Reviewed by: | |  | | |  |
|  | | | | | | | |  | |  | |  | | |  |
| **MEDICATION**  brand, generic name, dose | **APPEARANCE** type, shape, color | | **HOW MANY ?** | | **HOW TAKEN ?** | | **STARTED taking on:** | | **STOP taking on:** | | **REASON FOR TAKING** | | **WHO Told Me To Take This ?** | **NOTES** | |
| AS NEEDED |  | |  | |  | |  | |  | |  | |  |  | |
| equate, Ibuprofin, 200mg | tablet, round, brown, "1-2" | | 1 tablet | | by mouth, with water | |  | |  | | NSAID, pain killer, fever reducer | |  |  | |
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| AFTER WAKING UP |  | |  | |  | |  | |  | |  | |  |  | |
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| AFTERNOON |  | |  | |  | |  | |  | |  | |  |  | |
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| EVENING |  | |  | |  | |  | |  | |  | |  |  | |
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| BEFORE BED |  | |  | |  | |  | |  | |  | |  |  | |
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| *This worksheet and information should not replace the advice of a qualified healthcare worker.* | | | | | | | | |  | |  | |  |  | |