Master Medication List

Keep a list of your medications with you at all times

For: _____

PRINT YOUR NAME HERE DATE OF BIRTH

Allergies: _____

*Include **all** prescriptions, over-the-counter medicines, birth control, patches, inhalers, eye drops & herbals*

Medication Name	*Dosage or Amount*	*Form Taken* *(pill, injection...)*	*How often taken?* *(once or twice daily)*	*Prescribing Doctor*