

**My Medication Information Sheet**  
 Courtesy of the Pediatric Pharmacy Advocacy Group ([www.ppag.org](http://www.ppag.org))

Personal Information	Caregiver Information	My Allergies		Physician Information	Pharmacy Information
My name is:	Name:	Drug or Food	Reaction	My primary care physician is:  Phone:	Name:
My birth date is:	Phone #:				Phone #:
My phone # is:	Address:				Address:

**My Medications (please include all "over-the-counter" medications, vitamins, herbals, supplements, etc)**

Medication Name	Strength (mg)	Amount Taken	How often/what time of day?	What is it for?	Prescribing Physician/Specialty	Refills Remaining	Date Started/ Stopped
EXAMPLE: ADEKs		½ tab	Daily-7:30 AM	Vitamin	Dr. Breatheasy/ Pulmonary	5	July 1, 2005

Please use page 2 for additional medications.

		Medication Safety Tips
Current Height:	Additional Physicians/Specialties:	1.) Discard any unused or expired medications. 2.) Keep a list of your medications with you at all times. 3.) When you see multiple physicians, let them know when starting or stopping a medication. 4.) Discuss your current medications with your pharmacist or physician before taking any new medications (including vitamins, herbal supplements, over-the-counter products, etc.). 5.) Mark your calendar when prescription refills will be needed. 6.) Try to fill all of your prescriptions at one pharmacy.
Current Weight:		

Please refer to page 2 for directions.

