

MEDICATION SUMMARY

NAME:

Doctors' name and phone numbers:

Medical Insurance Company and ID number:

Pharmacists' name and phone numbers:

Prescription Drug Plan and ID number:

Emergency contact numbers:

Name:

Relationship:

Phone numbers:

Name:

Relationship:

Phone numbers:

My medical conditions include (circle or list):

Other conditions (list):

Abnormal EKG

Angina

Arthritis

Depression

Diabetes

Epilepsy

Hearing impairment

Heart condition

Hemodialysis

High blood pressure

Pacemaker

Visual impairment

Food allergies (list):

I am allergic to

(circle or list):

Insect bites

Aspirin

Antibiotics

Codeine

Other medications (list):

Name of prescription medicine	What it is for	Doctor who prescribed	How and when to take	How much to take/dosage/strength	Color/Shape
Name of non-prescription medicine (include OTC, vitamins, minerals, herbs, and home remedies)	What it is for	Doctor who prescribed	How and when to take	How much to take/dosage/strength	Color/Shape

For more copies, go to <http://noahnet.myweb.uga.edu/plansmm.html>.