Date/year you last received the following:	Flu Vaccine:	Tetanus/other:				
	Pneumonia Vaccine:	Hepatitis Vaccine:	Allergies and reactions (please describe):			

For copies of this form, visit www.christianacare.org/healthtools



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Christiana Care is a private, not-for-profit regional health care system and relies in part on the generosity of individuals, foundations and corporations to fulfill its mission. To learn more about how you can support our mission, please visit christianacare.org/donors. *My Medication List*







My Medication List

Name_____

Pharmacy _____ Phone _____

Emergency Contact _____

You can help make your health care safer by keeping this list up to date. Review and change this list when medicines are stopped, doses are changed or new medicines are added. Give this list to any doctor or health care provider caring for you. Carry this information with you at all times in case an emergency happens.

List all prescriptions, (those you get from your pharmacist), over the counter medicines (those you buy from your drugstore), vitamins, herbs, dietary supplements, oxygen, inhalers and home remedies.

Medication Name/ Date Started	Dose (mg, units, drops)	When Taken (daily, at bedtime, etc.)	Reason for Taking (blood pressure, diabetes, etc.)	Doctor Ordered