

MEDICATION SUMMARY

My medical conditions include (circle or list):

Abnormal EKG
Angina
Arthritis
Depression
Diabetes
Epilepsy
Hearing impairment

Heart condition
Hemodialysis
High blood pressure
Pacemaker
Visual impairment

Other conditions (list):

I am allergic to (circle or list):

Insect bites
Aspirin
Antibiotics
Codeine
Other medications (list):

Food allergies (list):

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:

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 <u>non-prescription</u> 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>.