Medication List

Parent name _____ Date of birth _____

Last checked _____ Checked by _____

Allergies / Warnings

_____

_____

_____

Copy names and doses exactly from the label. Include vitamins, supplements, and over-the-counter products.
Questions about medications? Ask the pharmacist or doctor.

Medication 1

Medication name * _____ Frequency _____

Strength _____ Unit _____ Form _____

Amount per dose _____ *e.g. 120 mg tablet, ½ per dose → 60 mg*

Dosage (free text) _____

Prescribing doctor _____ Prescribed date _____

Pharmacy name _____ Pharmacy phone _____

Last refill date _____ Next refill date _____ Refills remaining _____

Notes _____

_____

Medication 2

Medication name * _____ Frequency _____

Strength _____ Unit _____ Form _____

Amount per dose _____ *e.g. 120 mg tablet, ½ per dose → 60 mg*

Dosage (free text) _____

Prescribing doctor _____ Prescribed date _____

Pharmacy name _____ Pharmacy phone _____

Last refill date _____ Next refill date _____ Refills remaining _____

Notes _____

_____

Medication List (continued)

Parent name _____ Page _____

Medication

Medication name * _____ Frequency _____

Strength _____ Unit _____ Form _____

Amount per dose _____ *e.g. 120 mg tablet, ½ per dose → 60 mg*

Dosage (free text) _____

Prescribing doctor _____ Prescribed date _____

Pharmacy name _____ Pharmacy phone _____

Last refill date _____ Next refill date _____ Refills remaining _____

Notes _____

Medication

Medication name * _____ Frequency _____

Strength _____ Unit _____ Form _____

Amount per dose _____ *e.g. 120 mg tablet, ½ per dose → 60 mg*

Dosage (free text) _____

Prescribing doctor _____ Prescribed date _____

Pharmacy name _____ Pharmacy phone _____

Last refill date _____ Next refill date _____ Refills remaining _____

Notes _____

Medication

Medication name * _____ Frequency _____

Strength _____ Unit _____ Form _____

Amount per dose _____ *e.g. 120 mg tablet, ½ per dose → 60 mg*

Dosage (free text) _____

Prescribing doctor _____ Prescribed date _____

Pharmacy name _____ Pharmacy phone _____

Last refill date _____ Next refill date _____ Refills remaining _____

Notes _____