The Next Chapter Daytime Senior Care & Activities

MEDICATION LIST

Client Name:			
Nickname:	Sex:	Date of Birth:	Marital Status:
Address:			
City:	State:	Zip:	Seasonal: Yes / No

IMMUNIZATION RECORD - Record the month & year of last dose taken *(if known or applicable)*		
Tetanus	Flu Vaccine(s)	
Pneumonia Vaccine	Hepatitis Vaccine	Other

Allergic To:	**Describe Reaction:**

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:
Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Also, please include medications taken as needed and specify if it is **scheduled** or **as needed (PRN)** in the description.

DIRECTIONS - exact from label must include:

(a) # of meds *(1 pill, 1 tablet, 1 capsule, 1 eye drop, etc.)*
(b) # of times per day *(breakfast, lunch, dinner or bedtime – 2x daily, once daily, at bedtime, etc.)*
(c) route of medication taken *(oral or by mouth, eye, topical, etc.)*
(d) reason for the medication *(COPD, heart disease, hypertension, cholesterol, etc.)*

Example: "Take one (1) pill by mouth twice (2x) daily for COPD"

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Name of Medication	**Dosage**	**Time of Day**	**Directions** *(exact from label - (a) # of pills (b) # of times per day (c) route of med taken (oral, eye, topical, etc.)*	**Reason**