Other Important Information:	Date of Most Recent Add Immunizations:				Wallet Medic	cation Card	
	Pneumonia:	Phone: _			Name:	·	
	Tetanus:	Name: _			Phone:		
	Hepatitis:	Phone:	Phone:		Emergency Co	ntact Name:	
	Flu:						
What medications should I include? Prescription medicines Over-The-Counter medicines Vitamins		_			Emergency Contact Phor		
	Allergies:	Pharmad	cies:				
Herbal remedies Nutrition pills		Phone: _				CONNECTICUT	
Respiratory therapy medicines (such as inhalers)		Name: _			CHA	HOSPITAL ASSOCIATION	
Blood factors (such as Factor VIII) IV solutions IV nutrition		Phone: _					
Fold he							

Start date	Drug Name & (Strength)	Dose (pills, units, puffs, drops)	When do you take it? How many times a day? Morning & night? After meals?	Reason Why do you take it?	Start date	Drug Name & (Strength)	Dose (pills, units, puffs, drops)	When do you take it? How many times a day? Morning & night? After meals?	Reason Why do you take it?
1/1/06	Medicine (40 mg) (Example)	2 pills	Once a day with dinner	Heart					