AFC-29
9/09

MEDICATION INFORMATION SHEET

(Pharmacy information sheet may replace this format)

Resident _____ Birthdate _____

Doctor _____ Phone # _____

Pharmacist _____ Phone # _____

Medication _____
(brand name) (generic name)

Date prescribed _____ Can be refilled _____ times

Reason prescribed _____

Duration of treatment (how long drug should be taken) _____

Dose/times per day: _____

Times at which medication is to be taken _____

How medication is to be taken (e.g. “with food”, “on empty stomach”): _____

_____

Special handling/storage instructions: _____

_____

Side effects: _____

_____

Food, activities, or other drugs to avoid: _____

_____

Is medical alert identification needed? _____Yes _____ No

What procedure should be followed in case of?

Adverse reaction? _____

Drug interaction? _____

Dose not taken? _____

Vomiting? _____