Medication Allergies and Sensitivities

Medication | Type of Reaction

_____

_____

_____

Conditions I am being treated for:

1. _____

2. _____

3. _____

Name _____

Date of Birth _____

Doctors Name _____

at Phone No: _____

In Emergency call: _____

at Phone No. _____

Pharmacy _____

at Phone No. _____

My Personal

MEDICATION RECORD

Provided by your family physician
and Mercy Medical Center
on (date)_____

Mercy Medical Center Merced
A member of CHW

PRESCRIPTION, NON-PRESCRIPTION, VITAMINS & HERBAL MEDICATIONS I AM TAKING REGULARLY OR AS NEEDED.
(CROSS OUT IF DISCONTINUED)

Medication Name / Strength	Directions

Date

Flu Vaccine _____

Pneumonia Vaccine _____

ALWAYS KEEP THIS CARD WITH YOU

cut here

fold here

cut here