

**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? \_\_\_\_\_