Medication Matters

Avera

Name: _____

Height: _____

Weight: _____

Insurance Information:

_____

Emergency Contact:

_____

Phone: _____

Hospital Preference: _____

Advanced Directive: ❑ Yes ❑ No

Living Will: ❑ Yes ❑ No

Durable Power of Attorney for Health Care:

❑ Yes ❑ No

Name: _____

Phone: _____

Relationship: _____

Status: ❑ Independent ❑ Needs Assistance

_____

Date of last flu shot: _____

Date of last pneumonia vaccination: _____

Allergies/Sensitivities: _____

_____

Medical Conditions/Major Surgeries:

_____

_____

Tips for your medication safety:

- List all medications you are taking, including over-the-counter drugs, supplements, herbal products, eye drops and inhalers.
- Use only one pharmacy if possible.
- Always carry this card with you.

Date	Medication Name	Strength/ Dosage	How Often?	Why do you take this?	Prescribing Physician