Over-the-counter Drugs

_____

_____

_____

_____

_____

Herbals/Vitamins/Supplements

_____

_____

_____

_____

Vaccinations: *(Date Given)*

Pneumovax _____

Influenza _____

Tetanus _____

List all medication you are taking, including over the counter drugs and herbals

Cross off medication you no longer take.

Keep Med-Card with you at all times

Show Med-Card

*to your doctor each visit

*at the hospital

*at the emergency room

*at your pharmacy(s)

Allergies

_____

_____

_____

Pella Regional Health Center

your name

.....

MedCard

for your wallet

Emergency Contact

Name _____

City _____

Phone _____

Name of Pharmacy: #1 _____ Phone #1 _____

#2 #2

Generic Name Medication	Trade Name Medication	Dosage - How Often Taken	Prescribing Doctor