For your safety and good health, use this handy form to list all of your medications, including prescription drugs, herbal supplements, and vitamins.

Ask your pharmacist for a print out of your prescription drug history.

Share this list with your health care providers at all visits so there is common agreement on what you are taking and to avoid drug-drug interactions.

Make copies. Give them to loved ones and keep one with you at all times.

Update your record when starting or stopping a new medication or changing a dose.

Jefferson Township Fire Department

My Personal Information

Name: ____________________

Date of Birth: ____________________

Phone Number: ____________________

Emergency Contact

Name: ____________________

Relationship & Phone Number: ____________________

Primary Care Physician

Name: ____________________

Phone Number: ____________________

Pharmacy/Drugstore

Name: ____________________

Pharmacist: ____________________

Phone Number: ____________________

Other Physicians

Name: ____________________

Specialty: ____________________

Phone Number: ____________________

Name: ____________________

Specialty: ____________________

Phone Number: ____________________

Name: ____________________

Specialty: ____________________

Phone Number: ____________________

My Allergies

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My Medical Conditions

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