PARENTS ARE OK
Senior Safety

Current Medication List

Parent: _____ **Date of birth:** _____ **Last updated:** _____

Medication allergies / known reactions: _____

1. Current Medication List

Include prescription and over-the-counter medicines, vitamins, supplements, and medicines taken only when needed.
*(**M** = **M**orning | **L** = **L**unch | **D** = **D**inner | **N** = **N**ight)*

Medication (name)	Strength / Dose	When taken				What is it for
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	
		M	L	D	N	

2. Recent medication changes (after appointments, hospital visits, side effects)

Started / Stopped / Dose Changed: _____ When / Date: _____

Started / Stopped / Dose Changed: _____ When / Date: _____

Keep close:

1. Health Overview
2. Medical Log
3. Medical Documents & Test Results
4. ID, Insurance & Legal Documents