

Medication & Allergy List

Medication list last updated: _____

Bring this list to every appointment and pharmacy visit. Write the date on each added page. Ask the doctor or pharmacist before starting, stopping, or changing any medication.

Name of the person I support: _____

Date of birth (optional): _____

Reviewed by (doctor/pharmacist) and date: _____

Pharmacy & phone: _____

Emergency contact & phone: _____

ALLERGIES AND REACTIONS *(write "No known allergies" if none)*

Allergen	Type: medicine / food / other	Reaction

CURRENT MEDICATIONS *(prescription medications the person I support takes now)*

Medication name & strength	Dose / how taken	When / how often	Taken for	Prescriber	Start date	Notes

Free to print and share. From Lighthouse by Dragonfly, an iPhone app for organizing care information, medications, and appointments. lighthousebydragonfly.com
Private health information—store securely.



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AS-NEEDED (PRN) MEDICATIONS*Copy directions exactly from the current prescription label or care plan. If unsure, ask the pharmacist or prescriber before giving.*

Medication & strength	Dose / how taken	When to give	Minimum interval / maximum in 24 hours

VITAMINS, SUPPLEMENTS AND OVER-THE-COUNTER ITEMS

Name & strength	Amount	When / how often	Notes

RECENTLY STOPPED MEDICATIONS

Medication name & strength	Stopped date	Why it was stopped

NOTES FOR THE CARE TEAM

