Other Important Information:	Date of Most Recent Adult Immunizations:	Doctors:
What medications should I include? Prescription medicines Over-The-Counter medicines Vitamins Herbal remedies Nutrition pills Respiratory therapy medicines (such as inhalers) Blood factors (such as Factor VIII) IV solutions IV nutrition	Pneumonia: Tetanus: Hepatitis: Flu: **Allergies and Reactions:** **Advance Directive:** **Organ Donor:** Yes☐ No☐	Name: Phone: Name: Phone: Name: Phone: **Pharmacies:** Name: Phone: Name: Phone:

Wallet Medication Card

SYCAMORE INTEGRATED HEALTH

Name:

Phone:

Emergency Contact Name:

Emergency Contact Phone:

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Start date	Drug Name & (Strength)	Dose (pills, units, puffs, drops)	When do you take it? How many times a day? Morning & night? After meals?	Reason Why do you take it?
1/1/06	Medicine (40 mg) **(Example)**	2 pills	Once a day with dinner	Heart

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Start date	Drug Name & (Strength)	Dose (pills, units, puffs, drops)	When do you take it? How many times a day? Morning & night? After meals?	Reason Why do you take it?