Medication Record

PLEASE carry updated card at all times.

Name:______________________________

Doctor:______________________________

Pharmacy:____________________________

Emergency Contact:____________________

List any allergies/bad reactions and what caused them:

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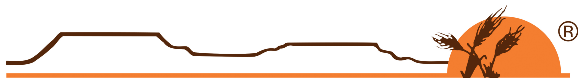
Flu Shot:____________________________

Pneumonia Shot:______________________

Tetanus Shot:_________________________

Shingles Shot:________________________

Compliments of:



WEST RIVER HEALTH SERVICES

701-567-4561 www.wrhs.com

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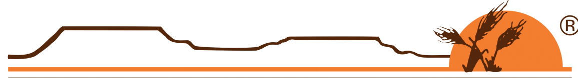

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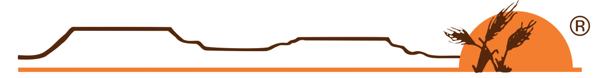

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MEDICATIONS I AM TAKING REGULARLY OR AS NEEDED (including any non-prescription, herbals, injections, eye/ear/nose drops, inhalers, nebulizer treatments, etc)

Medicine/Strength	Directions/Use

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