



SCOTT & WHITE DRUG CARD – KEEP IN WALLET

Doctor _____

Name _____ Date of Birth _____

1. Please read all handout materials when picking up medications from the pharmacy.
2. Before leaving, look at the medication and label, check to be sure both are correct.
3. What is the purpose of the medication?
4. What does the medication look like?
5. How and when do I take this medication?
Never take medications in the dark.

6. Take medication exactly as prescribed on the label.
7. What should I do if I miss a dose?
8. Does this medication have any side effects?
What should I do if they occur?
9. Does this medication cause problems with any other medications, foods or over-the-counter products?
10. How should I store this medication?

List Drug and Food allergies or write **no allergies**

List all medications including over-the counter products:

NAME - DOSE - HOW OFTEN - TIME OF DAY - START DATE

(Continue on the other side)

Continued from other side:

NAME - DOSE - HOW OFTEN - TIME OF DAY - START DATE

2002