ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

Name: _____

UNIVERSAL MEDICATION FORM

(Always keep this form with you. Instructions on page 4.)

Name	Date of Birth	Sex (circle one)	Height	Weight
		Male Female		

Address	Phone Number(s)	Emergency Contact
	Home:	Name:
	Work:	Relation:
	Mobile:	Phone:

Allergies (please describe reaction)		

Doctor / Dentist / Other Prescriber's Name	Phone Number	Type of Practitioner / Reason for Seeing

Pharmacy Name	Phone Number	Street/City/State	Immunizations (Date of Last Dose)
			□ Tetanus:
			□ Pneumonia Vaccine:
Additional Information / Comments			□ Flu Vaccine:
			□ Hepatitis Vaccine:
			□ Other:

Date Updated: _____