

### Emergency Contacts

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

### Physician Contact

Physician Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Physician Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Physician Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_

### My Pharmacy

Pharmacy Name: \_\_\_\_\_  
Location: \_\_\_\_\_  
Phone #: \_\_\_\_\_

### My Medication Card

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_



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### About Me

Blood Type: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_  
Religion: \_\_\_\_\_  
Date this card was completed: \_\_\_\_\_

### Date of Immunizations:

Tetanus: \_\_\_\_\_  
Pneumococcal: \_\_\_\_\_  
Influenza: \_\_\_\_\_  
Other: \_\_\_\_\_  
Organ Donor: Yes \_\_\_ No \_\_\_

I have named a Health Care Proxy: Yes \_ No \_

*If yes, who should be contacted?*

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

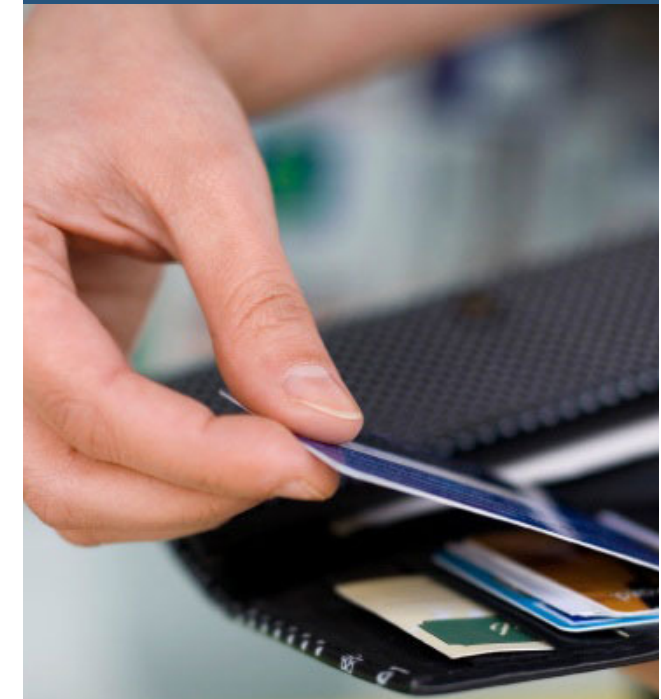
I have a Living Will: Yes \_\_\_ No \_\_\_

### MANAGING YOUR MEDICINES

- **Write your questions down** ahead of time. Keep a list of questions you want to ask your health care team. Take the list with you to your appointment.
- **Take notes** when you get information from your health care team.
- **Bring a friend or family member** with you when you visit the doctor. Talking over what you do with someone you trust can help you make better decisions.
- **Try to use the same pharmacy** to buy all of your medicines so your prescription records will all be in one place.
- **Tell your doctor, nurse and pharmacist** about the medicines you currently take, including over-the-counter vitamins and supplements, and if you have had problems when taking a medicine before.

## NANTUCKET COTTAGE HOSPITAL

### Medication Card



Use this Medication Card to keep track of your medicines, medical conditions and emergency information.

Nantucket Cottage Hospital  
57 Prospect Street - Nantucket, MA 02554  
phone: 508.825.8100 - fax: 508.825.8133  
[www.NantucketHospital.org](http://www.NantucketHospital.org)



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# Medication Safety Begins with You

## TIPS FOR FILLING OUT THIS MEDICATION CARD

Your Medication Card can help you and your family keep track of everything you take to keep you healthy: your pills, vitamins and herbs.

Make the list of all your medicines and everything else you take. Your doctor can help with vaccinations and other shots. Your pharmacist can give you a list of all medications prescribed to you. Be sure to include medicine that you take from all pharmacies that you use and any over-the-counter medicines, vitamins, herbs or minerals that you take.

Think about what you take in the morning, afternoon, around dinner time and before you go to bed.

### Speak Up!

You should never be afraid to ask your doctor, nurse or pharmacist about your medicines.  
Your health is too important.

For each medicine that you take (including those you get without a prescription), vitamin or herbal remedy, write down these things for the appropriate space on the Medication Card:

- **Drug Name:** list the name of what you take: Tylenol, aspirin, etc.
- **Color /Shape of Pill:** indicate shape and/or type, round, white and red, clear liquid.
- **Strength** of the does: 80 mg., 20 mg., a capful, etc.
- **Dosage** amount: one pill, two teaspoons, three drops, two puffs.
- **How Often/When** you take it: morning with water, at dinner time, before bed
- **What is it For:** arthritis, for your heart, to lower cholesterol?
- **Who Prescribed it:** your family doctor, your arthritis specialist, etc.

**I am taking the following medications:**  
(Include over-the-counter vitamins & supplements)

Drug Name	Color/Shape of Pill	Strength	Dosage	How Often / When	What is it For / Who Prescribed it

### Medical Conditions & Allergies

Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Known Allergy: \_\_\_\_\_ Reactions? \_\_\_\_\_

Known Allergy: \_\_\_\_\_ Reactions? \_\_\_\_\_

Known Allergy: \_\_\_\_\_ Reactions? \_\_\_\_\_

Have this information verified by your physician or pharmacist each visit.

**Keep this card with you at all times.**