

Medication List

Fill this in from the bottles, not from memory. Make a new copy the day anything changes.

For _____ Last changed _____

Allergies and reactions _____ Pharmacy phone _____

Medicine (name on the bottle)	Dose	Times	What it is for	Prescribed by	Pharmacy	Refill due

Supplements and over-the-counter medicines (they belong on the list too)

Medicine (name on the bottle)	Dose	Times	What it is for	Prescribed by	Pharmacy	Refill due

Bring a copy to every appointment and leave one with every prescriber, including the dentist and the eye doctor.

Daily Care Sheet

One page per day, for the handoff between whoever is here today and tomorrow.

Date _____ Caregiver(s) today _____

Medications given	Given	Initials	Notes (refused, late, side effects)
Morning	☐		
Midday	☐		
Evening	☐		
Bedtime	☐		

Meals Breakfast _____ Lunch _____ Dinner _____ Snacks _____	Fluids (cups or glasses) _____ _____ _____ _____
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Mood and alertness _____ _____ _____	Mobility, pain, falls _____ _____ _____
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Visits and appointments today

Notes for the next person

