

Medication Checklist

Name of Patient: _____ Prescription Date: _____

When filling out the Medication Checklist Template for your patients, we recommend creating separate entries for each instance a medication is taken throughout the day.

Name of Medication	Dosage	Time	Duration	Tick the boxes when you have taken the medication
				<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat
				<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat
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				<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat

Additional Notes

Write any reminders and additional details for the patient here, such as what side effects to expect, what to do in case of overdose or what symptoms should signal to stop taking medication. The patient can write down any questions here, too.

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