Bring your medication records and insurance cards with you to all medical appointments, and to the hospital.

MY MEDICATION RECORD
EMERGENCY MEDICAL RECORD
Provided by Salem Hospital West Valley Hospital
A part of Salem Health

Medical conditions for which I am being treated:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have the following allergies and sensitivities: (Please include type of reaction)

_____
_____
_____
_____
_____
_____

Date of last vaccinations:

Tetanus _____

Flu _____

Pneumonia _____

Do you have an:
Advance Directive (Living Will)? ☐ Yes ☐ No

Where is it filed? _____

Have you filled out a Donor Card? ☐ Yes ☐ No

_____
Name

_____
Address

_____
Phone

_____
Physician

_____
Physician's Phone

_____
Pharmacy

_____
Pharmacy Phone

In an emergency, please call: (please list a friend or relative)

_____
Name

_____
Phone

Salem Hospital West Valley Hospital
A part of Salem Health

665 Winter Street SE
Salem, OR 97301
(503) 561-5200
www.salemhospital.org

I am taking the following medications regularly or as needed: ***(Please list all prescriptions, over-the-counter, and/or herbals. Please cross out any medications that you are no longer taking.)***

DATE	MEDICATION NAME	STRENGTH (mg, mEq, eTC)	DIRECTIONS/REASON FOR TAKING
Example:	*Lanoxin*	*0.25 mg.*	*Once a day (heart)*

Courtesy of Salem Hospital