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PATIENT MEDICATION LOG

LOMA LINDA UNIVERSITY
CHILDREN'S HOSPITAL

Patient Name: _____

Date of Birth: _____ / _____/_____ (mm/dd/yyyy)

Allergies/Reaction: _____

Date started/stopped	Drug Name (brand/generic)	Dose	Route	How often	Scheduled Times	What is this medication for?

Bring this form with you any time you have a doctor's appointment or have to go to the hospital.