Epilepsia en Washington:
Improving Access to Care for Children & Youth

MY MEDICINE SCHEDULE

My Name: ______________________ My Phone Number: ______________________
Doctor Name: ______________________ Office Number for Refills: ______________________
Pharmacy Name: ______________________ Phone Number: ______________________

Medication	Purpose	Date Started	Date Stopped	Dose	When to Take (add time of medicines)					Prescribed By

Allergies: ______________________

DOH 970-120

Washington State Department of Health