# Discharge Medication Schedule as of (Date):

Include all prescription and over‐the‐counter medications, vitamins and herbal supplements.

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| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_ | I.D. No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Name** | **Reasons For Taking The Medicine** | **DOSAGE** | **Instructions** |
|  |  | |  |  |  | | --- | --- | --- | | Morning | Afternoon | Night | |  |
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| **Additional Medications as Needed** | | | |
| **Additional Medications As Needed** |  |  |  |
| **Discontinued Medications** | | | |
| **Do Not Take the Following** |  |  |  |
| **Avoid the following:** | | | |
| **Avoid the Following** |  | | |