My Medicine

Fill in this check list with your mum/dad/carer or a doctor, nurse or pharmacist to help you understand more about your medicine and how to use it safely.

My name is: ____________________

I have: (Condition/Illness) ____________________ **My medicine is:** ____________________

It makes me feel ill here...

Mark where you feel ill...

Inhaler ☐ Pills ☐ Syringe ☐

Tube of cream ☐ Liquid ☐ Ointment ☐

This medicine works by: ____________________

I take my medicine: ________ **times** ☐ **a day** ☐ **a week** ☐ **when I feel I need it**

I take my medicine at:

12 9 3 6   12 9 3 6   12 9 3 6   12 9 3 6

I keep taking my medicine until: (date) ____________________ **or my treatment changes**

I keep my medicine safely here:

Cabinet ☐ Fridge ☐ School Bag ☐ Teacher ☐ Parent/Carer ☐

1 + 2 = 3

Anything else I need to remember: ____________________

If you have any questions about your medicines you can ask a doctor, nurse, pharmacist or your mum/dad/carer.