Medication Action Plan

Taking medicines every day can be hard, and most people forget to take their daily medicines sometimes. The goal of this “Medication Action Plan” is to help increase how often you take your medicines.

Goal for the next week

What is your goal for improving how you often you want to take your medicines next week? There is no right or wrong answer. For some people this may mean taking it twice a day every day, and for others, taking it 5 times/week might be an improvement.

Link to an existing habit

Scientists have found that a good way of improving how often people take their medicines is by linking it to a HABIT they already have.

HABITS are things people do automatically and without thinking. For example, flushing the toilet after they use the restroom, brushing their teeth at night, or plugging in their phone to charge at night. Let’s use this worksheet to help you plan how and when you take your medicines by linking it to a HABIT you already do every morning and evening.

Morning

Evening

Environmental Cues

What will you see/do specifically to make you think of taking your meds?

- Examples: “When I put my toothbrush in the canister…” or “ When I see my meds next to the phone charger…”

Support and accountability

Who or what will support you in meeting your goals and how?

- Examples: Parent/Guardian (daily/weekly check in), phone alarm

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Reward

Let’s work with your parent or guardian to pick rewards that work for you and your family.

Your DAILY reward should be a little extra treat for taking your meds at the end of day.

- Examples: extra screen time, time doing a hobby, choosing a movie or show, a snack of your choice, etc.

Your WEEKLY award should be given if you meet your goal for the week.

- Examples: $5 at the end of the week, a night out with friends, an extended curfew etc.

Daily	Weekly

Track Your Medications

Use this section to list all the prescription medications you are taking. For each medication, provide the dosage (for example: 1 puff, 2 pills, etc) and how often you take it (once per day, twice per day, weekly. etc).

Medication: _____ Dosage:_____ How Often: _____

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Medication: _____ Dosage:_____ How Often: _____

Mark the box below for each day you take ALL your EoE medications.

Month: _____

M	T	W	T	F	S	S	Fill in the star if you meet your weekly goal
							☆
							☆
							☆
							☆
							☆