MEDICAL INFORMATION

Keep this record with you at all times

Name _____

Address _____

_____

Phone _____

In case of emergency, dial 911

EMERGENCY CONTACTS

In case of emergency, please contact

Name _____

Phone _____

Doctor _____

Phone _____

Doctor _____

Phone _____

Pharmacy _____

Phone _____

Other _____

Phone _____

In case of emergency, dial 911

CHRONIC CONDITIONS

Indicate any ongoing medical concerns

- ☐ Bloodpressure
- ☐ Asthma
- ☐ Diabetes
- ☐ Heartdisease
- ☐ Cancer
- ☐ Other

In case of emergency, dial 911

PRESCRIPTION MEDS

List prescription medications you are currently taking

Med	Dose	Time

In case of emergency, dial 911

OVER THE COUNTER

List your current over-the-countermedications

- ☐ Aspirin
- ☐ Antacids
- ☐ Allergyrelief
- ☐ Coldmedicine
- ☐ Dietpills
- ☐ Laxatives
- ☐ Sleepaid
- ☐ Vitamins
- ☐ Supplements

- ☐ Other

In case of emergency, dial 911

ALLERGY RECORD

List all allergies and your reaction

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

In case of emergency, dial 911

IMMUNIZATION RECORD

Enter the date you were last immunized

Tetanus _____

Flu _____

Pneumonia _____

Hepatitis _____

Other _____

_____

_____

In case of emergency, dial 911

NOTES

Add any additional information here

In case of emergency, dial 911

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In case of emergency, dial 911

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