EMERGENCY MEDICAL INFORMATION CARD

Date form updated: Month:_____ Year:_____

Name:_____ Phone:_____

Address:_____

Date of Birth:_____ Blood Type:_____

Parent/Legal Guardian:_____

Do Not Resuscitate Form is attached, or located at:

_____

EMERGENCY CONTACTS

Name:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

Address:_____

Name:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

Address:_____

MEDICAL CONDITIONS

1._____

2._____

3._____

4._____

Allergies:_____

Primary Physician:_____

Phone:_____ Fax:_____

Specialty Physician:_____

Phone:_____ Fax:_____

Hospital Preference:_____

Other Information/Remarks

_____

_____

_____

_____

Current Medications	Dosage	Frequency

Pharmacy:_____ Phone:_____

Primary Language:_____

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