


DIRECTIONS

1. Save or print several blank copies of this form for future use.
2. When filling out this form on your Computer, use the **TAB** key to move to a new line and/or point & click in the shaded areas with your mouse.
3. On one copy, fill in the blanks, using the "Additional Information" section on this part of the form if you need more space.
4. Copy the completed form.
 - a. Cut along the scissors line. 
 - b. Fold the form to fit into a wallet or large luggage tag (it will be the size of a credit card when folded in fourths.)
5. Highlight the words "Medical Information" at the top of the form.
6. Remember to list any changes in your medications so that this record is always current.
7. Keep this record with you, even when you are not carrying your full wallet.

REMEMBER

1. Always have this information with you, so you have it in an emergency.
2. Give a copy to all your doctors, your pharmacist and your dentist, so they are kept up-to-date about your medications.
3. Revise this list whenever your medications change, so you remember what you are currently taking.

FOLD HERE

FOLD HERE

MEDICAL INFORMATION

Name: _____
 Address: _____

Date of Birth: _____

Social Security #: _____
 (optional)

Insurance Information: _____

Blood Type: _____

Drug or Food Allergies: _____

Medical Conditions: _____

Medications, Vitamins, Herbs and Supplements	Dose	Frequency

(Continue on next page)

IN CASE OF EMERGENCY

Physician
 Name: _____
 Tel: _____

Contact Persons
 Name: _____
 Tel: _____
 Name: _____
 Tel: _____

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Date Updated: _____

Additional Information

Other Physicians:

Physician
Name: _____
Tel: _____

Physician
Name: _____
Tel: _____

Date Updated: _____

Medical Information Continued

Medications Dose Freq.

Vitamins, Herbs
and Supplements Dose Freq.

**Durable Power of Attorney
for Health Care Decisions:
(Optional)**

Name: _____
Tel: _____
Name: _____
Tel: _____

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