My Essential Medical Information

My name is: _____

The name I like to be called is: _____

My phone number is: (_____) _____ – _____

My birthdate is: Month _____ Date _____ Year _____

My blood type is: *(check one)* ☐ A+ ☐ A- ☐ B+ ☐ B- ☐ AB+ ☐ AB- ☐ O+ ☐ O-

I have these medical illnesses, conditions, or disorders:

_____

_____

_____

These are the names and phone numbers of my medical providers:

_____ (_____) _____ – _____

_____ (_____) _____ – _____

_____ (_____) _____ – _____

_____ (_____) _____ – _____

I currently take the following medication(s):

Medication _____ Dosage _____

Medication _____ Dosage _____

Medication _____ Dosage _____

Medication _____ Dosage _____

I am allergic to: _____

I use these assistive devices: _____

Living Safely
with disabilities and special health needs

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