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: _________________________________

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