KEEP MEDICAL INFORMATION UP TO DATE
Review at Least Every 6 Months: Updated as of _____

** Note we ask you to complete this form and put a **copy in the medicine bottle and put in your refrigerator**, we also would ask you to carry this form with you in your **wallet** (see below) in case you are out. Thank you!!

Name: _____ Date of Birth: _____

Address: _____Religion: _____ Blood Type: _____

Social Security # _____

Medication/Food Allergies: _____

Medical Issues: _____

Surgical History: _____

Medications:

_____

EMERGENCY CONTACTS:

Name: _____Phone # _____

Relationship to the above: _____

Doctor: _____Phone # _____

Pharmacy: _____ Phone # _____

Is there a NO CPR/DNR directive? ____ Yes ____ No If yes, where is it located? **refrigerator**, **wallet**

Special instructions (e.g. Funeral home, etc.)

_____

Cut here ----------Cut here

For your Wallet

Name: _____ Address: _____Date of Birth_____ Religion: _____
Blood Type: _____

Social Security # _____Medication/Food Allergies: _____Medical Issues:
_____

Surgical History: _____

Medications: _____

EMERGENCY CONTACTS:

Name: _____ Phone # _____Relationship to the above:
_____

Doctor: _____ Phone # _____Pharmacy_____ Phone #
_____

Is there a NO CPR/DNR directive? ____ Yes ____ No If yes, where is it located? **refrigerator**, **wallet**
Special instructions (e.g. Funeral home, etc.)

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