PERSONAL EMERGENCY INFORMATION FOR

Name ____ Nickname: _________________________

DOB: ___________________ Cell # _________________________ Home # ___________________

Home Address: ____

Additional information (e.g. people living with you): _______________________________________

____

Emergency Contact ____

Phone #'s ____ Relationship ___________________

ALLERGIES (drugs and food):

Allergy	Reaction

HEALTH PROVIDERS:

Name	Role	Phone	Fax
	PCP		
	PHARMACY		

MEDICAL CONDITIONS:

Condition	Notes

Date completed: ____________
Date updated: ______________

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MEDICATIONS (prescription, over-the-counter, vitamins, supplements, etc):

Medication Name & Strength	Dose & Frequency	Prescriber (if any) Purpose of medication

□ IF MARKED, SEE ADDENDUM "ADDITIONAL MEDICATIONS" FOR MORE ITEMS

MEDICAL DEVICES (e.g. insulin pump, blood glucose monitor, etc.)

Device & Purpose	Model # Lot #	Additional supplies or instructions

IMMUNIZATION HISTORY (partial):

VACCINE	DATE	VACCINE	DATE	VACCINE	DATE
Annual Flu		Hepatitis B			
Tetanus/diphtheria/pertussis		Hepatitis A			

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Date updated: ______________

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