

EMERGENCY MEDICAL INFORMATION CARD

PERSONAL DETAILS			EMERGENCY CONTACTS			
PATIENT DETAILS Full Name: _____ Date of Birth: _____ Street Address: _____ City / Province / State: _____ Postal / ZIP Code: _____ Country: _____ Primary Phone: _____ Preferred Language: _____ Blood Type: _____ Organ Donor (Y/N): _____ Height: _____ Weight: _____ Allergies: _____ Last Updated: _____			PRIMARY CONTACT Name: _____ Relationship: _____ Phone: _____ Alternate Phone: _____ SECONDARY CONTACT Name: _____ Relationship: _____ Phone: _____ Alternate Phone: _____ HEALTHCARE / INSURANCE Doctor / Clinic: _____ Doctor Phone: _____ Insurance Provider: _____ Policy / Member No.: _____			
MEDICAL CONDITIONS			MEDICATION & DOSAGE			
<i>List diagnoses, chronic conditions, allergies, implants, or other important emergency information.</i>			<i>List current prescription medicines, over-the-counter medicines, and essential supplements.</i>			
Condition / Allergy	Since	Notes / Provider	Medication	Dose	Time / Frequency	Purpose / Notes
SPECIAL MEDICAL NOTES / DEVICES _____ _____ _____ _____			PHARMACY Pharmacy Name: _____ Phone: _____ PHARMACY Pharmacy Name: _____ Phone: _____			

Keep this card current and accessible. In an emergency, call local emergency services.