## MEDICAL INFORMATION

*Keep this record with you at all times*

Name _____

Address _____

_____

Phone _____

In case of emergency, dial 911

www.FreePrintableMedicalForms.com

## EMERGENCY CONTACTS

*In case of emergency, please contact*

Name _____

Phone _____

Doctor _____

Phone _____

Doctor _____

Phone _____

Pharmacy _____

Phone _____

Other _____

Phone _____

In case of emergency, dial 911

www.FreePrintableMedicalForms.com

## CHRONIC CONDITIONS

*Indicate any ongoing medical concerns*

☐ Blood pressure

☐ Asthma

☐ Diabetes

☐ Heart disease

☐ Cancer

☐ Other

In case of emergency, dial 911

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## PRESCRIPTION MEDS

*List prescription medications you are currently taking*

| Med | Dose | Time |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

In case of emergency, dial 911

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## OVER THE COUNTER

*List your current over-the-counter medications*

☐ Aspirin

☐ Antacids

☐ Allergy relief

☐ Cold medicine

☐ Diet pills

☐ Laxatives

☐ Sleep aid

☐ Vitamins

☐ Supplements

☐ Other

In case of emergency, dial 911

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## ALLERGY RECORD

*List all allergies and your reaction*

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

Allergy _____

Reaction _____

In case of emergency, dial 911

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## IMMUNIZATION RECORD

*Enter the date you were last immunized*

Tetanus _____

Flu _____

Pneumonia _____

Hepatitis _____

Other _____

_____

_____

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## NOTES

*Add any additional information here*

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