

Emergency Data & Medication List

Name _____ Birthdate _____

Physician _____ Phone number _____

Emergency Contacts:

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Do you have an Advanced Directive or a DNR form? Circle one: Yes No

If so, where is it located? _____ Blood type _____

Medical Conditions/Health Issues/Recent Surgeries:

Drug and Food Allergies:

List all prescription medications (RX) and all Over-the-counter (OTC), including supplements, pain relievers, antacids, laxatives, and herbal remedies.

| Medications | | | | |
|---------------|------|----------|-----------------------------|------------------|
| Type (Circle) | Name | Strength | Form (tablet, liquid, etc.) | How often taken? |
| RX OTC | | | | |
| RX OTC | | | | |
| RX OTC | | | | |
| RX OTC | | | | |
| RX OTC | | | | |
| RX OTC | | | | |
| RX OTC | | | | |
| RX OTC | | | | |

Date last updated _____

Keep this information on your refrigerator and/or inside your medicine cabinet and put a copy in your wallet or purse.