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:

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Drug and Food Allergies:

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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.