EMERGENCY INFORMATION

(Post on refrigerator)

Name:	**Date Card Completed:**
Address:	**Telephone Number:**
Date of Birth:	**Blood Type:**

EMERGENCY CONTACTS:

Name:	**Phone:**
Name:	**Phone:**
Name:	**Phone:**
Doctor's Name:	**Doctor's Phone:**
Health Care Plan:	**Medicare No.:**
Major Illnesses:	
Allergies to Medications:	

MEDICATIONS

CURRENT MEDICATIONS	DOSAGE/ STRENGTH	HOW OFTEN TAKEN	WHEN TAKEN