

PERSONAL INFORMATION

(in case of emergency)

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Primary Care Physician

Name: _____

Location: _____

Phone: _____

Other physician names/locations:

Pharmacy name: _____

Location: _____

Phone: _____

Emergency contact name/relationship:

_____/_____

Phone: _____

Health Care Agent (Proxy) name:

Phone: _____

BE MED SMART

Know it...

Bring it...

Show it...

PERSONAL INFORMATION

(in case of emergency)

Medication Allergies:

Food Allergies:

- Eggs
- Peanuts
- Shellfish

Other Allergies: _____

 Latex

Vaccinations

Date

Influenza (Flu) _____

Tetanus _____

Pneumococcal _____

Hepatitis B _____

Hepatitis A _____

Measles/mumps/rubella _____

Chicken pox _____

Diphtheria/pertussis/tetanus
(DPT) _____



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