MEDICAL IDENTIFICATION CARD

PLEASE KEEP A COPY OF THIS ON YOUR REFRIGERATOR

Name:	Emergency Contact Name:	Emergency Contact Name:
Address:	Address:	Address:
City, State, Zip:	City, State, Zip:	City, State, Zip:
Phone:	Phone:	Phone:

ALLERGIES:			Physician:	Power Of Attorney:
Medical Directives:	YES NO	Blood Type:	Phone:	Phone:

MEDICAL HISTORY: *Circle Current Diseases and Past Surgeries*

Asthma Atrial Fibrillation Bleeding Disorder Cancer Cerebrovascular Disease Chronic Obstructive Pulmonary Disease

Chronic Renal Insufficiency Congestive Heart Failure Coronary Artery disease Current Smoker Diabetes High Cholesterol

Hypertension / High Blood Pressure Immunodeficiency Disease Mental Illness Neuro Muscular Peripheral Vascular Disease

Previous Heart Attack Seizures Stroke / TIA OTHER:

Adenoidectomy Appendectomy Gall bladder Hernia Repair Hysterectomy Implanted Devices Open Heart Prosthetics

Stent Placement Tonsillectomy Tubal Ligation OTHER:

CURRENT MEDICATIONS

Name of Drug	Dosage	Route	Time	Reason

ADDITIONAL INFORMATION:

DATE FORM COMPLETED: UPDATED: UPDATED: UPDATED: