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EMERGENCY MEDICAL INFORMATION

(07/22/2015)

DATE COMPLETED: _____ **COMPLETED BY:** _____

NAME: _____ **DATE OF BIRTH:** _____

HOME ADDRESS: _____

TELEPHONE: _____ **PREFERRED HOSPITAL:** _____

EMERGENCY CONTACT (NAME & PHONE #): _____

DOCTOR(S) (NAME & PHONE #): _____

PAST MEDICAL HISTORY (INCLUDING ILLNESSES, INJURIES AND SURGERIES)

_____

_____

_____

CURRENT MEDICAL PROBLEMS (INCLUDING ILLNESSES, INJURIES AND SURGERIES)

_____

_____

_____

_____

_____

ALLERGIES:

_____

_____

APPROXIMATE WEIGHT (POUNDS): _____ **SEX:** ❑ **MALE** ❑ **FEMALE**

MEDICATIONS (INCLUDE PRESCRIPTION, NON-PRESCRIPTION AND HERBAL PRODUCTS)

MEDICATION NAME	DOSAGE	WHEN TAKEN (TIMES)	CONDITION FOR WHICH TAKEN
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MEDICATIONS (INCLUDE PRESCRIPTION, NON-PRESCRIPTION AND HERBAL PRODUCTS)

MEDICATION NAME	DOSAGE	WHEN TAKEN (TIMES)	CONDITION FOR WHICH TAKEN

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