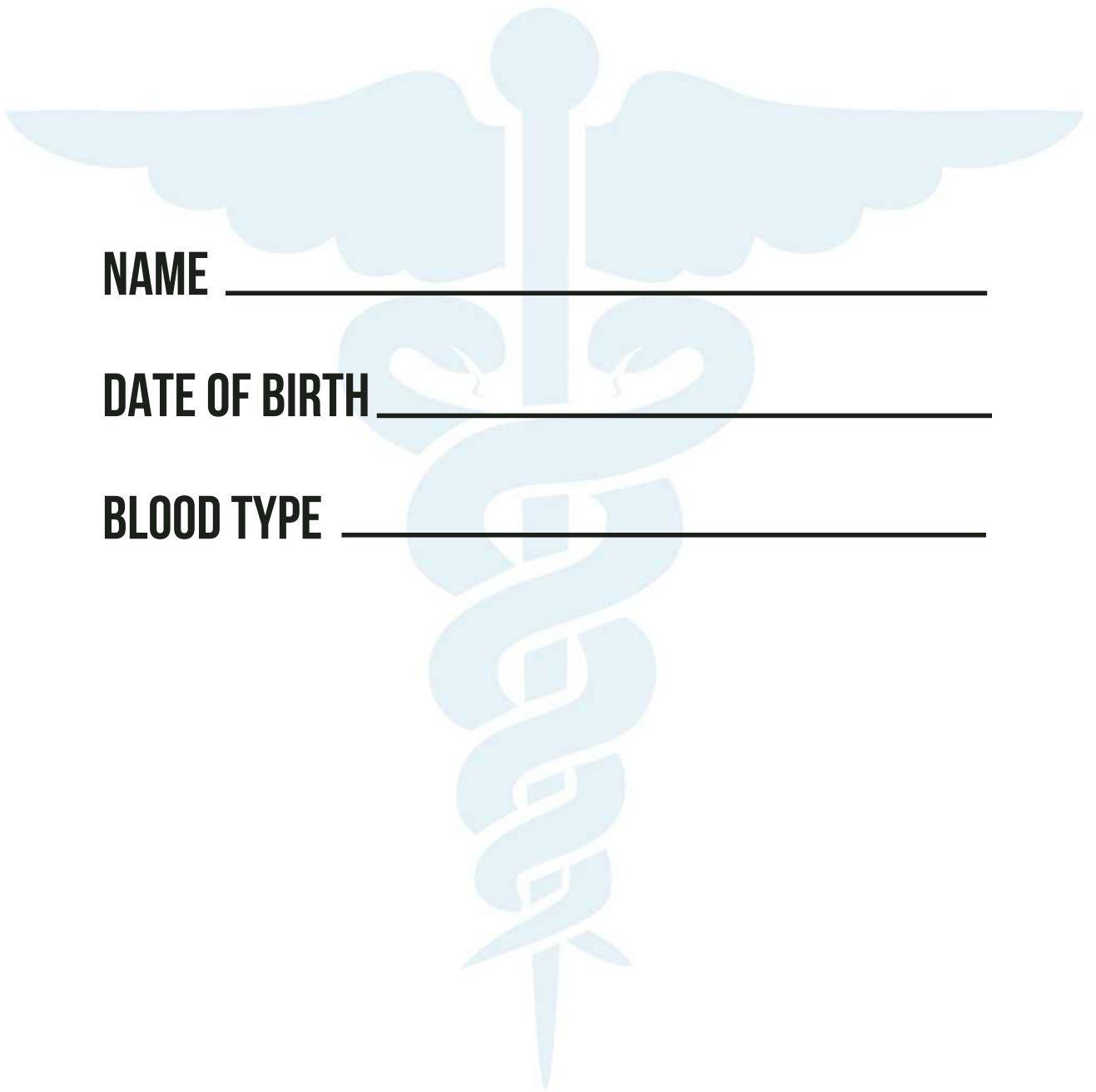


EMERGENCY MEDICAL JOURNAL

NAME _____

DATE OF BIRTH _____

BLOOD TYPE _____





Current Physicians

Name, Specialty, Contact Information and Hospital Affiliation

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Name: _____ Specialty: _____

Phone: _____ Hospital Affiliation: _____

Last Updated: _____



Allergies

Life Threatening: (Type and Reaction) (IE: Penicillin & anaphylactic shock)

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Last Updated: _____



Allergies

Non -Life Threatening: (Type and Reaction)

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Last Updated: _____



Medications

Breakfast

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Lunch

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Bedtime

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Last Updated: _____



Supplements

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

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Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Last Updated: _____



Pharmacies

Name: _____ Phone Number: _____

Account number if necessary: _____

Name: _____ Phone Number: _____

Account number if necessary: _____

Name: _____ Phone Number: _____

Account number if necessary: _____

Name: _____ Phone Number: _____

Account number if necessary: _____

Name: _____ Phone Number: _____

Account number if necessary: _____

Name: _____ Phone Number: _____

Account number if necessary: _____

Last Updated: _____



Temporary Medications

Antibiotics, Newly Prescribed for a short period of time, additional medications

Breakfast

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Lunch

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Dinner

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Bedtime

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Name: _____ Dosage: _____ Time Dispensed: _____

Last Updated: _____



Medical History

Surgery: _____ Date: _____

Physician: _____ Hospital: _____

Surgery: _____ Date: _____

Physician: _____ Hospital: _____

Surgery: _____ Date: _____

Physician: _____ Hospital: _____

Surgery: _____ Date: _____

Physician: _____ Hospital: _____

Surgery: _____ Date: _____

Physician: _____ Hospital: _____

Surgery: _____ Date: _____

Physician: _____ Hospital: _____

Last Updated: _____



Last Updated: _____



Vaccinations

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Name: _____ Date Received: _____

Last Updated: _____



ICE (In Case of Emergency) &

Additional Contact Phone Numbers

ICE (In Case of Emergency): In order of preference

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Power Of Attorney

Name: _____ Phone: _____ Relationship: _____

Personal Contacts: Alphabetical Order/As Necessary

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____ Last Updated: _____



My Personal Information & Preferences

(short bio of your loved one)

Name: _____ Date of Birth: _____

Current Address: _____

Insurance Information

Company Name: _____

Policy No: _____ Group No: _____

Medicare: _____

Policy No: _____ Group No: _____

Optional Short Bio of your Loved One:

Last Updated: _____