

MEDICAL INFORMATION SHEET

Name: _____

SSN: _____

Address: _____

Telephone: _____

Date of Birth: _____

Health Care Plan: _____

Doctor's Name: _____

Doctor's Phone: _____

Allergies: _____

Medication: _____

Major Illnesses: _____

Emergency Contact: _____

Medic Alert No. _____

Advanced Directive (Living Will, No CPR, etc.) _____

Yes _____ **No** _____

If yes, where is information located: _____

Keep on your refrigerator in case of Emergency