Medical Conditions

(List conditions such as: diabetes, heart disease, epilepsy, etc.)

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Allergies

(Example: medicine, foods, latex, etc.)

Allergen and Reaction

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____

Blood Type: __________ Tetanus Vaccine Date: ______________

Flu Vaccine Date: ______________________________

Pneumonia Vaccine Date: ______________________________

____

Date of Birth

____

Phone Number

____

Address

____

City, ST Zip

____

Emergency Contact Name

____

Relationship/Phone #

Medical Information

____

Name

____

Primary Physician

____

Pharmacy

www.huronregional.org

Prescription Medications (Write dose in pencil if it changes frequently.)

Medication	Dose	Directions	Reason
Example: Lasix	*20 mg*	*once a day*	*fluid retention*

Over-the-Counter/Herbals

(Ex. vitamins, supplements, etc.)

Name and Dose

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