Emergency health information

Full name:

Date of birth:

Address:

Phone number:

Emergency contact/phone #:

Primary healthcare provider/phone #:

Medical information

Blood type:

Allergies:

Immunizations:

Medical conditions:

Medical devices (e.g., pacemaker or insulin pump):

Medication taken and dosage

Insurance information

Provider:

Policy number: | Group number:

Subscriber name:

Preferred pharmacy:

Additional notes and advance directives

*Keep a printed copy of this sheet in an easily accessible location. Update it after any medication, diagnosis, insurance, or healthcare provider change.