MEDICAL AND PRESCRIPTION RECORDS

MEDICAL INFORMATION

My allergies and drug sensitivities:_____

_____

My blood type:_____

Medical conditions I have:_____

_____

DOCTORS WHO ARE TREATING ME

Name_____ Specialty_____ Phone_____

Name_____ Specialty_____ Phone_____

Name_____ Specialty_____ Phone_____

Hospital_____

Name_____ Emergency Phone Number_____

Pharmacy_____

Name_____ Phone_____

Dentist_____

Name_____ Phone_____

Optometrist_____

Name_____ Phone_____

Prescription Information

Name of drug ______________________

Date prescribed ______________________

Doctor's name ______________________

Prescribed for what? ______________________

Color/shape/strength ______________________

Directions/cautions ______________________

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Name of drug ______________________

Date prescribed ______________________

Doctor's name ______________________

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Color/shape/strength ______________________

Directions/cautions ______________________

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