Please Print

EMERGENCY MEDICAL INFORMATION

M	F

B.C. Care Card Number _____

NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: (Month) _____ (Day) _____ (Year) _____

DOCTOR/LNP: _____ Office Phone # _____

HOSPITAL OF CHOICE : _____

EMERGENCY CONTACTS

NAME OF CONTACT	Telephone & / or Email	RELATIONSHIP TO YOU

POWER OF ATTORNEY
On file at:

MEDICAL DATA: as at (Month)_____ (Day) _____ (Year) _____

BLOOD TYPE: _____

ALLERGIES:

_____

_____

MEDICAL DATA CONTINUED

DATE OF RECENT SURGERY(IES):(Month) _____ (Day) _____ (Year) _____

Surgical Type:

Name of Surgeon(s):

Remarks and other Special Conditions etc.

MEDICATIONS

Prescriptions	Dosage	Frequency (time of day, with/without food)

Location where medications are kept:

Pharmacy Name & Phone Number (optional) _____