

vial of L.I.F.E.®

My Medical Wallet Card

Program sponsored by:



fold

Date _____

Name _____

Date of Birth _____

Allergies _____

Height _____ Weight _____

Contact Lens Living Will Organ Donor

Yes No Yes No Yes No

fold

Emergency Contact

Name _____

Telephone _____ Relationship _____

Primary Care Provider/Family Doctor

Name _____

Telephone _____

Durable Power of Attorney

Name _____

Telephone _____

Current Medications

(Example: Lasix 20 Mg. 1 tablet 2x day)

Medical Conditions / History

Special Circumstances / Notes

(Primary language, hospital preference, hearing, etc.)

Directions: cut along outside dotted line and fold along center line.