IMPORTANT HEALTHCARE INFORMATION

COMPLETE AND KEEP IN A VISIBLE PLACE IN CASE OF MEDICAL EMERGENCY

Name _____ **Birth Date**_____

Address_____ **Home Phone** _____

Email _____ **Cell Phone** _____

Emergency Contact Names and Phone Numbers

1. _____
2. _____

Doctor Contact Names and Phone Numbers

1. _____
2. _____

Medical Conditions

_____

_____

_____

_____

_____

_____

Allergies to Medication/Food

_____

_____

I have completed a Designated HealthCare Agent form on file.

☐ YES ☐ NO

Medical Information Wallet Card

_____ **Name**

_____ **Cell Phone**

_____ **Doctor Name**

_____ **Doctor Phone**

Howard County LHIC
Local Health Improvement Coalition
Howard County Health Department

Emergency Contact

_____ **Name**

_____ **Phone**

_____ **Address**

_____ **Birthdate**

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Howard County Health Department

Medical Information Wallet Card

_____ **Name**

_____ **Phone**

_____ **Doctor Name**

_____ **Doctor Phone**

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Emergency Contact

_____ **Name**

_____ **Cell Phone**

_____ **Address**

_____ **Birthdate**

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IMPORTANT HEALTHCARE INFORMATION

COMPLETE AND KEEP IN A VISIBLE PLACE IN CASE OF MEDICAL EMERGENCY
LIST PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATIONS USED

Name	Dose	Last updated

UPDATE THIS LIST ANYTIME YOUR MEDICATIONS CHANGE AND REVIEW AT LEAST ONCE A YEAR WITH YOUR PRIMARY CARE PROVIDER

Howard County LHIC
Local Health Improvement Coalition
Howard County Health Department

REMEMBER TO DISPOSE OF MEDICATIONS PROPERLY.
VISIT WWW.HCLHIC.ORG FOR MORE INFORMATION

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies

_____
_____

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies

_____
_____