

WHO AM I?

Keep this record with you at all times

Name: _____

Address: _____

Phone: _____

Other: _____

EMERGENCY CARE

Please Contact Care Champion*

*Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Doctor: _____

Phone: _____

Doctor: _____

Phone: _____

CHRONIC CONDITIONS

Indicate any ongoing medical concerns

☐ Blood pressure

☐ Asthma

☐ Diabetes

☐ Heart disease

☐ Cancer

☐ Other

PRESCRIPTION MEDS

List prescription medications you are currently taking

MED

DOSE

TIME

OVER THE COUNTER

List your current over-the-counter medications

- ☐ Aspirin
- ☐ Antacids
- ☐ Allergy relief
- ☐ Cold medicine
- ☐ Diet pills
- ☐ Laxatives
- ☐ Sleep aid
- ☐ Vitamins
- ☐ Supplements
- ☐ Other

ALLERGY RECORD

List all allergies and your reaction

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

IMMUNIZATION RECORD

Enter date of last immunization

Tetanus _____

Flu _____

Pneumonia _____

Hepatitis _____

Covid Type _____

Covid Dates _____

Other _____

MEDICAL CARE NOTES

CARE CHAMPION NOTES

NEIGHBOR NOTES