# My Medical Wallet Card

Sponsored by:

Fold-----------------------------------------------------------------------

Date: ____________ Date of Birth:___________

Name: ______________________________________

Phone:______________________________________

Allergies: ___________________________________

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Height:_________ Weight:_________

Fold------------------------------------------------------------------------

Emergency Contact

Name: ______________________________________

Phone:______________________________________

Primary Care Provider/Family Doctor

Name: _____________________________________

Phone:______________________________________

Current Medications: ________________________

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Medical Conditions/History: _________________

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Special Circumstances/Notes: _______________

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