

Emergency Contact and Medical Information Date Completed:

Name:	DOB (date of birth):
Address:	Age:
	Phone:

Emergency Contact Name:	
Address:	cell phone:
	work phone:

Medical History:
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Resting Vitals:				
Time:				
HR:				
RR:				
BP:				
Weight:				

Allergies:
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Reaction:
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Treatments:
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Epi Pen: Y / N
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Past Medical History:
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