Medical Information List

Please complete this form and distribute copies to your emergency contact people as well as to each member in your network.

Primary physician: _____

Telephone number: _____

Address: _____

Hospital affiliation: _____

Address: _____

Type of health insurance: _____

Policy number: _____

Blood type: _____

Allergies and sensitivities: _____

Medications and dosages being taken: _____

Specific medical conditions and/or physical limitations: _____

Adaptive equipment and vendors' phone numbers: _____

Communication difficulties I may have include: _____

Cognitive difficulties I may have include: _____