## EMERGENCY MEDICAL INFORMATION

NAME OF CONTACT  Telephone & / or Email  RELATIONSHIP TO YOU  POWER OF ATTORNEY On file at:  MEDICAL DATA: as at (Month) (Day) (Year) (	B.C. Care Card N	lumber		<u> </u>	M F
DATE OF BIRTH: (Month) (Day) (Year)  DOCTOR/LNP: Office Phone #  HOSPITAL OF CHOICE:  EMERGENCY CONTACTS  NAME OF CONTACT Telephone & / or Email RELATIONSHIP TO YOU  POWER OF ATTORNEY On file at:  MEDICAL DATA: as at (Month) (Day) (Year)  BLOOD TYPE:	NAME:				_
OOCTOR/LNP: Office Phone #  HOSPITAL OF CHOICE :  EMERGENCY CONTACTS  NAME OF CONTACT					-
HOSPITAL OF CHOICE :  EMERGENCY CONTACTS  NAME OF CONTACT	DATE OF BIRTH: (Month)	(Day)	(Year)		
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On file at:  MEDICAL DATA: as at (Month) (Day) (Year) (Year) BLOOD TYPE:					
BLOOD TYPE:	POWER OF ATTORNEY On file at:				
ALLERGIES:			(Year)		
	ALLERGIES:				

EDICAL DATA CONTINUED			
ATE OF RECENT SURGERY(IE	S):(Month)	(Day)	(Year)
Surgical Type:			
lame of Surgeon(s):			
idilie of Surgeon(s).			
emarks and other Special Co	nditions etc.		
<u>EDICATIONS</u>			
Prescriptions	Dosage	Frequency (time of	of day, with/without food)
ocation where medications ar	e kept:		
ocation where medications ar	e kept:		