**PERSONAL EMERGENCY INFORMATION**

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| **Name** |  | | | | | | | | | | | |
| **Address** |  | | | | | | | | | | | |
| **City** |  | | | | | | | **State** | |  | **ZIP** |  |
| **Date of Birth** | |  | | | | | | | | | | |
| **Phone Number** | | | |  | | | | | | | | |
| **Cell Phone Number** | | | |  | | | | | | | | |
| **Height** | | | |  | | | | | **Weight** | |  | |
| **Allergies/Reactions** | | | |  | | | | | | | | |
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| **Blood Type** | | | |  | | | | | | | | |
| **Medical Conditions/Cautions** | | | | | |  | | | | | | |
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| **Medications/Dosages** | | | |  | | | | | | | | |
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| **Assistive Devices & Dentures** | | | | | | |  | | | | | |
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| **Emergency Contacts** | | | |  | | | | | | | | |
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| **Physicians & Phone #’s** | | | | |  | | | | | | | |
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| **Advanced Directives/Location** | | | | | | |  | | | | | |
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| **Other Information** | | |  | | | | | | | | | |
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**PERSONAL EMERGENCY INFORMATION**

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| **Address** |  | | | | | | | | | | | |
| **City** |  | | | | | | | **State** | |  | **ZIP** |  |
| **Date of Birth** | |  | | | | | | | | | | |
| **Phone Number** | | | |  | | | | | | | | |
| **Cell Phone Number** | | | |  | | | | | | | | |
| **Height** | | | |  | | | | | **Weight** | |  | |
| **Allergies/Reactions** | | | |  | | | | | | | | |
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| **Blood Type** | | | |  | | | | | | | | |
| **Medical Conditions/Cautions** | | | | | |  | | | | | | |
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| **Medications/Dosages** | | | |  | | | | | | | | |
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| **Assistive Devices & Dentures** | | | | | | |  | | | | | |
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| **Emergency Contacts** | | | |  | | | | | | | | |
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| **Physicians & Phone #’s** | | | | |  | | | | | | | |
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| **Advanced Directives/Location** | | | | | | |  | | | | | |
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| **Other Information** | | |  | | | | | | | | | |
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