Medical Information

(Duplicate as needed: One for everyone on board)

Name: _____

Blood Type: _____

Emergency Contact #1:

Name:_____

Relationship:_____

Phone:_____

Emergency Contact #2:

Name:_____

Relationship:_____

Phone:_____

Known Health Conditions:

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Known Allergies:

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Current Medications:

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Eyeglass Prescription Details:

Left Eye: _____

Right Eye: _____

Notes: _____

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Preferred Physician:

Name:_____

Phone:_____

Email:_____

Preferred Pharmacy:

Name:_____

Phone:_____

Website:_____