LETTER FOR LIFE

Please fill in as much information as you can in the fields below.
Fold and place it in the magnetic envelope provided.

Full name	
Date of birth	Today's date

What medical problems do you have? **(Check/list all that apply)**

☐ Asthma/ COPD/ Emphysema	☐ Pacemaker/ Implanted Defib.
☐ Cancer	☐ Other medical problems
☐ Diabetes	
☐ Heart Problems	
☐ High Blood Pressure	
☐ Seizures	
☐ Strokes	

What medications do you take?

Drug name	Dose	Drug name	Dose

What allergies do you have? **(Check/list in spaces provided)**

☐ No known drug allergies	☐ Allergies

Place the Letter For LIFE in a visible area on the outside of your refrigerator. Please remember to update your information every 6 months or after any changes.

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Who is your emergency contact?

Name	Home phone
Relationship	Cell phone

Who are your Doctors?

Doctor's name	Specialty	Phone number

What hospitals do you go to?

Is there any other information about you we should know?

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Supplementary

Additional spaces for medical problems

Additional spaces for medications

Drug name	Dose	Drug name	Dose

Additional spaces for allergies

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