

My Medical Wallet Card

Sponsored by:



TREGO HOSPITAL
Endowment Foundation, Inc.

Fold-----

Date: _____ Date of Birth: _____

Name: _____

Phone: _____

Allergies: _____

Height: _____ Weight: _____

Fold-----

Emergency Contact

Name: _____

Phone: _____

Primary Care Provider/Family Doctor

Name: _____

Phone: _____

Current Medications: _____

Medical Conditions/History: _____

Special Circumstances/Notes: _____

Pharmacy

Name: _____

Phone: _____