

I HAVE BEEN TOLD BY MY PHYSICIAN I HAVE:

Asthma _____
 Dementia _____
 Diabetes _____
 Cancer _____
 Specify Type: _____
 Heart Disease _____
 Kidney Disease _____
 High Blood Pressure/ _____
 Hypertension _____
 Seizure Disorders _____
 Other: _____

IN CASE OF EMERGENCY:

Please Contact: _____ Relation: _____
 Phone: (____) _____ - _____
 OR
 Name: _____ Relation: _____
 Phone: (____) _____ - _____

Family Physician: _____ Phone: (____) _____ - _____
 Specialist: _____ Phone: (____) _____ - _____
 Specialist: _____ Phone: (____) _____ - _____
 Pharmacy: _____ Phone: (____) _____ - _____

IMMUNIZATION RECORD
Vaccination—Date

Influenza _____
 Pneumococcal (Pneumonia) _____
 Tetanus/Diphtheria _____
 MMR (Measles, Mumps, Rubella) _____
 PPD (Tuberculosis Test) _____

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ALLERGIES

List any food and/or drug allergies and the reaction you have.

<i>Food or Drug</i>	<i>Reaction</i>

HOW TO USE THIS CARD

1. Carry this card with you at all times.
2. Use pencil to list all medications, prescription or over-the-counter, you are taking.
3. Ask your doctor or pharmacist to help you complete any information you do not know.
4. Update your card each time your doctor changes or issues you a prescription. You want the information listed to be accurate.
5. Show this card to any doctor or specialist that treats you. Share it with any hospital, emergency department, etc. you may visit.

Name of my Dialysis Center: _____
 Phone # for Dialysis Center: (____) _____ - _____

MARC
 Mid-Atlantic Renal Coalition

**EMERGENCY
 MEDICAL
 INFORMATION
 CARD**

**DIALYSIS
 PATIENT**

DIALYSIS PATIENT INFORMATION

My name is _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Email _____

Height _____ Weight _____ Blood Type _____

Dialysis Access Type (circle one) AV-Fistula Catheter Graft

Primary Dialysis Method (circle one) Hemodialysis Peritoneal Dialysis

PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS TAKEN

Please list all using pencil, so corrections can be made as necessary. Include vitamins, aspirin, herbal remedies, etc.

Start Date	Name of Medication	Check if Prescribed	Check if Over-the-Counter	Dose Taken (mg, puffs, drops, etc.)	# Times per Day	Time of Day Taken

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