**Chronic Medications you take. Please list anything, Rx or OTC that you take on a regular basis. Please list the name, (brand or generic), the strength, and how many times a day you take your medication.**

**NAME----------STRENGTH----------HOW DO I TAKE IT**

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**Please list any surgeries you have had, as to type and the year performed.**

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**I hereby give authorization to any medical personnel, to use the above information, in case of a medical emergency.**

_____

**Sign your name and Date it and print your name**

_____

**Witness signs their name and Date it and print name**

_____

**Witness signs their name and Date it and print name**

**THIS MEDICAL FORM DESIGNED 30TH AUGUST 2006 / BETTY-MARIE B.REID, R.N., B.S.N., AND B. L. REID, D.PH.**