MY MEDICAL QUICK VIEW

VISIT DETAILS

NAME: _____ DONOR: _____ YES ☐ NO ☐

DATE OF BIRTH: _____ BLOOD TYPE: _____

HEIGHT: _____ WEIGHT: _____

MEDICAL CONDITIONS

ALLERGIES

ALLERGY _____ MEDS _____

REACTION _____

ALLERGY _____ MEDS _____

REACTION _____

ALLERGY _____ MEDS _____

_____

_____