**FRONT**

**Carry this card with you at all times. The information is essential to anyone who provides you with dental, medical, surgical or emergency care.**

**Allergies:** _____

_____

_____

**Date of Last Tetanus:** _____

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Name: _____

Address: _____

Telephone: _____

***In case of Emergency, Notify:***

Name: _____ Phone: _____

Local Doctor: _____

DHMC Doctor: _____

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# Medication Card

**MT. ASCUTNEY HOSPITAL**
AND HEALTH CENTER

289 County Road, Windsor, VT 05089
www.mtascutneyhospital.org

**(802) 674-6711**

**BACK**

| Medication | Dose | Time |
|---|---|---|
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