TULALIP
Container *for Life* shəliʔulč

TULALIP TRIBES
COMMUNITY HEALTH

Important medical information for (please print clearly)

First name	Last name

Street address			Home telephone
City	**State**	**Zip**	**Cell phone**
Date of birth	**Gender**		**Pet(s) in home**

Medical condition(s)

Doctor's name	Doctor's telephone

Current medication(s)	Dosage	Frequency	Medications (continued)	Dosage	Frequency

Allergies to medications

Special instructions

Emergency contact name	Relationship
Address	Contact telephone

Insert completed form into container and store it in refrigerator.

TDS-**39602** (03/2023)