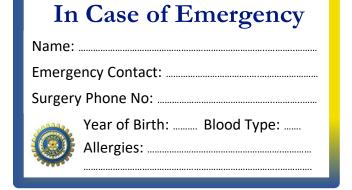
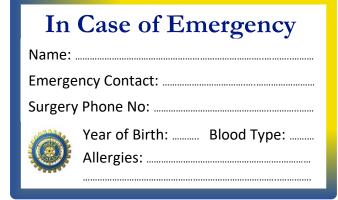
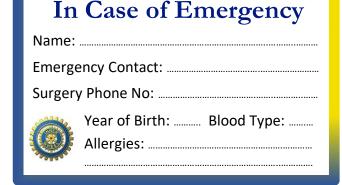
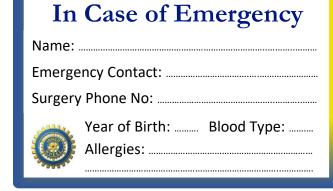
In Case of Emergency Name: Emergency Contact: Surgery Phone No: Year of Birth: Blood Type: Allergies:

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