MEDICAL CERTIFICATE

EMERGENCY KIT

Patient´s name: _____

Date of birth: _____ / _____ / _____
day month year

This is to certify that the above named person has the following medical items for private medical use or in case of an emergency medical situation.

	Amount	*Specification*
☐	_____	syringes
☐	_____	needles
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____

Date: _____ / _____ / _____
day month year

Official stamp of medical unit

Physician´s signature:

_____