Emergency Medical Information Form

PLEASE USE PENCIL TO FILL OUT OR MAKE CHANGES TO THIS FORM

Full Name:	Birth Date:	Weight:	Blood Type:

Street Address:	City:	State:	Zip:	Phone ( )

Next of Kin (Name):	Relationship:	Phone ( )

Other Emergency Contact:

Name:			Phone ( )
Street Address:	City:	State:	Zip:

Medical Conditions & Devices: **Please check mark ✓ [or circle] any that presently apply to you.**

	Acid Reflux (GERD)		Atrial Fibrillation		Dentures		Hepatitis (Type?_____)
	AIDS		Chronic Bronchitis		Dementia, Alzheimer's		Medicine Patch
	Angina		Cholesterol, High		Diabetes		Pacemaker
	Artificial Eye		Clotting Disorder		Emphysema		Renal Failure (dialysis?____)
	Asthma		Congestive Heart Failure		Glasses		Stroke
	Blood Pressure, High		Contact Lenses		Hearing Difficulty		Seizures
	Blood Pressure, Low		COPD		Heart Valve Condition		Tuberculosis
	Cancer		Pace Maker / Defibrillator		HIV Positive		Unable to Speak

Other medical conditions you are currently being treated for that aren't listed above:

List Medications to which you have *Allergies* >>>

Your Current Medications	Dose	Your Current Medications	Dose

LOCATION OF YOUR MEDICATIONS _____

Your Primary Doctor:_____ **City:**_____

Have you had any surgeries? If so, please list

Description	Date	Description	Date

Do you have a "No CPR" or "Do Not Resuscitate" document signed by your doctor?
If so, where are the original documents located?

Does another person have authority to direct your medical care?
(e.g., holder of Medical Power of Attorney, next of kin)

Name:			Phone ( )
Street Address:	City:	State:	Zip:

Ver. 05/22/2017