EMERGENCY MEDICAL INFORMATION

Keep Information Up-To-Date

Name: _____ Sex: M F

Address: _____ Date of Birth: / /

_____

EMERGENCY CONTACTS

Name: _____ Home Phone: _____

Address: _____

Relation: Work Phone:

Name: _____ Home Phone: _____

Address: _____

Relation: Work Phone:

MEDICAL DATA

Last Updated: Mon Year Blood Type:

Doctor: Phone #:

Doctor: Phone #:

Special Conditions / Remarks:

Recent Surgeries	Date

Religion:

Living Will on file at:

Health Care Proxy on file at:

Do you have a DNR Form? YES ☐ NO ☐

Where is it located? _____

MEDICAL CONDITIONS (check all that exist)

( ) No known medical conditions ( ) Abnormal EKG ( ) Angina
( ) Adrenal Insufficiency ( ) Asthma ( ) Bleeding Disorder
( ) Cardiac Dysrhythmia ( ) Cataracts ( ) Clotting Disorder
( ) Coronary Bypass Graft ( ) Dementia ( ) Alzheimer's
( ) Diabetes/Insulin Dependent ( ) Eye Surgery ( ) Glaucoma
( ) Heart Valve Prosthesis ( ) Hemodialysis ( ) Hemolytic Anemia
( ) Hypertension ( ) Hypoglycemia ( ) Laryngectomy ( ) Leukemia
( ) Lymphomas ( ) Malignant Hypothermia ( ) Memory Impaired
( ) Myasthenla Gravis ( ) Pacemaker ( ) Renal Failure
( ) Seizure Disorder ( ) Sickle Cell Anemia ( ) Stroke
( ) Hearing Impaired ( ) Vision Impaired ( ) Blind ( ) Deaf
Other_____

_____

_____

_____

_____

ALLERGIES (medication, food, other…)	

MEDICAL INSURANCE

Medical Insurance Company:

Policy #:

Other Medical Insurance Company:

Policy #:

Medicaid #: **Medicare #:**

MEDICATIONS	DOSAGE	FREQUENCY