CONFIDENTIAL EMERGENCY MEDICAL FORM

Please follow these instructions: Fill out this form and place it inside a sealed envelope.
Put your name on the outside of the envelope.

PLEASE PRINT

First Name: ________________________________ Last Name: ___________________________________

Address: ____

City: _____________________________________ State: _____________________ Zip Code: __________

Telephone #: (Home) _________________________ (Cell. Phone #) ______________________________

1st Emergency contact NAME: _________________________________ Relationship: ________________

Telephone #: (Home) _________________________ (Cell. Phone #) ______________________________

2nd Emergency contact NAME: ________________________________ Relationship: ________________

Telephone #: (Home) _________________________ (Cell. Phone #) ______________________________

Medication allergies: ____

Other allergies: ____

DOB: ___________________ Weight:______________ Height: ____________

Primary Care Physician Name: ____

City and State: ____

Phone #: ____________________________________

Health problems/conditions ____

____

Other physicians:

Name ____________________________________ Name____

Specialty __________________________________ Specialty ____________________________________

City and State______________________________ City and State _________________________________

Phone # ___________________________________ Phone #_______________________________________

Date of last tetanus shot _____________

Current prescription medications:

Name of medicine	Dose	How Often	Reason

Over-the-counter medications

Name of medicine	Dose	How Often	Reason

Previous surgeries:

What	When

Do you have any of these conditions?

Difficulty with anesthesia?	YES	NO
Past blood transfusion?	YES	NO
Do you wear glasses or contact lenses?	YES	NO
Do you wear dentures or partial plate?	YES	NO
Do you have difficulty hearing?	YES	NO
Do you smoke? If so, how much?	YES	NO
Have you been out of the country in the past 6 months?	YES	NO
Do you have a living will/durable power of attorney for health care?	YES	NO

Any other information Emergency Room physician should know about you? (please use back of form)

Insurance Plan: ____

Group #: _________________________________ Member's #: ________________________________

Phone # _________________________________

I authorize release of this information in a medical emergency to an EMT and/or Emergency Room Physician:

_______________________________________ _______________________

Signature Date