MEDICAL EMERGENCY FORM

Please complete this form and seal in the provided envelope. The envelope will only be opened in the event of an emergency. This information will be kept in strict confidence. Fire Department, Emergency Medical Services and Hospital Emergency personnel will be given this information in the event you cannot give vital information.

First Name _____ MI ____ Last Name _____ Date of Birth _____

Street Address _____ City _____ Zip _____

Phone 1 _____ Phone 2 _____

Insurance Carrier _____ Policy Number _____

Physician 1 Name _____ Phone Number _____

Physician 2 Name _____ Phone Number _____

Emergency Contacts

Name _____ Relationship _____ Phone 1 _____

Phone 2 _____

Name _____ Relationship _____ Phone 1 _____

Phone 2 _____

Vital Information

Blood Type _____

Allergies _____

Health Conditions (Diseases and History: Coronary Heart Disease, Congestive Heart Failure, Diabetes, Stroke, Cancer, High Blood Pressure, Chemical Sensitivities, etc.)

A _____ B _____

C _____ D _____

E _____ F _____

Medications (list any others on back)

Drug Name _____ Dosage _____ Frequency _____

Drug Name _____ Dosage _____ Frequency _____

Drug Name _____ Dosage _____ Frequency _____

Drug Name _____ Dosage _____ Frequency _____

Drug Name _____ Dosage _____ Frequency _____

Drug Name _____ Dosage _____ Frequency _____