

In Case of An Emergency

Date Form Completed: _____ Current Age: _____

INFORMATION IS FOR:

Last Name: _____

First Name: _____

Middle Initial: _____

Social Security Number: ____ - ____ - ____

Blood Type: _____

Medications Allergic To: (See Below)

EMERGENCY PHONE NUMBERS (besides 911):

Fire: _____

Police: _____

Ambulance: _____

Hospital: _____

DIRECTIONS- To provide Emergency Personnel *directions to your home*:

Subdivision or Condo Association: _____

Nearest Intersections: _____

Nearest Major Roads: _____

OTHER PERSONAL INFORMATION

Date of Birth: _____

House Number _____

Street: _____

City _____

State _____ Zip _____

Home Phone # (____) ____ - ____

Driver's License # _____

Height: _____ Weight: _____

Hair Color: _____ Eyes: _____

Pacemaker: () yes () no

Eye Glasses: () yes () no

Contact Lens: () yes () no

False Teeth: () yes () no

Birthmarks or Scars/Where: _____

PHYSICIAN(s):

Primary Care Doctor _____

City/State: _____

Telephone Number _____

Emergency Service _____

Specialist (identify)

City/State: _____

Telephone Number _____

Emergency Service _____

HOSPITAL(s) -

Name the *preferred hospital* or one covered by your insurance

If necessary transport me to the following hospital:

INSURANCE:

Primary

Carrier (i.e. Prudential etc) _____

Policy # _____ Group # _____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

Secondary (Medicaid, Medicare, etc.)

Carrier _____

Policy # _____ Group # _____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

EMERGENCY CONTACT(s)

Name _____

Relationship to you _____

Phone Number _____

Cell Phone/Pager _____

Name _____

Relationship to you _____

Phone Number _____

Cell Phone/Pager _____

OTHER PERTINENT DOCUMENTS/INFORMATION

If applicable, attach document to this sheet

Living Will () yes () no

Do Not Resituate () yes () no

Organ Donor: () yes () no

Medical Power of Attorney:

Person Designated: _____

Telephone Number _____

Cell Phone/Pager # _____

CHRONIC MEDICAL CONDITION(s)

(Identify, i.e. Huntington's Disease, Cancer, Congestive Heart Failure, Diabetic I or II, Emphysema, Epilepsy, Seizures, Kidney or Liver disease etc.)

Condition: _____

Diagnosed: _____

Specialist: _____

Condition: _____

Diagnosed: _____

Specialist: _____

OTHER MEDICAL CONDITIONS:

(Identify i.e. Hearing Loss, Blind, Anemia, Thyroid Disease, High Blood Pressure, etc.)

Condition: _____

Diagnosed: _____

Specialist: _____

Condition: _____

Diagnosed: _____

Specialist: _____

VACCINATIONS - Year of last vaccination

___ Tetanus/diphtheria

___ Pneumococcal vaccine

___ Flu vaccine

___ Measles, mumps, rubella

___ Polio

___ Varicella (chickenpox)

___ Hepatitis A

___ Hepatitis B

ALLERGIC TO - DO NOT GIVE:

(list everything i.e. Morphine causes rash, etc.)

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

SPECIAL INSTRUCTIONS:

Identify i.e.: Keep Calm/Tends To Hyperventilate When Excited-Seizure Prone;
Do Not Use Restraints; Keep Head Elevated/Swallowing Difficulties, etc.

CURRENT PRESCRIPTION MEDICATION(s)

List or use the Medication Form and say "See Attached"

ADDITIONAL CONTACTS - (To Be Made By Family, **Not** EMS, I.e. employer, other emergency contacts, funeral homes, clergy, etc.)

Organization: _____
Person To Contact _____
Telephone No. _____

Organization: _____
Person To Contact _____
Telephone No. _____

Organization: _____
Person To Contact _____
Telephone No. _____

THIS PERSON IS UNDER AGE 18

This form is for my child, under age 18. Permission is granted to treat my child in an emergency

() Yes. () No, contact me prior to treating.

Parent Name: _____
Emergency Telephone Number: _____

Signature: _____