

# MEDICAL EMERGENCY INFORMATION FORM

*(We recommend that you post this information on your refrigerator)*

*(You could also copy this form and carry it in your wallet/purse)*

NAME:	DATE OF BIRTH:
ADDRESS:	PHONE #:
PRIMARY DOCTOR:	DOCTOR'S PHONE #:

EMERGENCY CONTACT PERSON #1	EMERGENCY CONTACT PERSON #2
NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE #:	PHONE #:

### YOUR HEALTH INFORMATION (CHECK ALL THAT APPLY)

- DIABETIC       DEFIBRILLATOR/PACEMAKER       HEART TROUBLE   
 EPILEPSY                   HIGH BLOOD PRESSURE                   EMPHYSEMA   
 DENTURES                           KIDNEY PROBLEMS                   HEARING AID   
 CONTACT LENSES                           OTHER  (Please explain other below)

---



---

ALLERGIES  (List all) \_\_\_\_\_

### LIST OF CURRENT MEDICATIONS

NAME	DOSAGE	NAME	DOSAGE

(If you fill these boxes, continue list on back of form)