EMERGENCY INFORMATION FORM

Please update this form at least annually, or with any major change to your medical status.

Complete both sides of the form, place in gallon size sealable plastic bag along with your Advanced Directive (MOLST, DNR, Living Will), Current EKG from Cardiologist (if you have one) and

ATTACH TO YOUR REFRIGERATOR

Also keep one in the glove box of your car

Date Form Completed:			Revision Dates:	
First Name	Middle Initial		Last Name	
Address:			City, State & Zip	
Phone #			Date of Birth	
☐Male ☐Female		Height:	Weight:	Blood Type:
Religion:			Native Language if not English:	
Identifying Marks:			Pacemaker/AICD ☐Yes ☐No	

☐Hearing Aid-Left Ear ☐Hearing Aid-Right Ear ☐Hearing Aid-Both Ears ☐Deaf
☐Dentures-Upper ☐Dentures-Lower ☐Dentures-Both ☐Glasses
☐Contacts ☐Blind ☐Artificial Eye-Left
☐Artificial Eye-Right ☐Prosthetic

MEDICAL HISTORY

☐AIDS ☐Blood Pressure ☐Epilepsy ☐Heart Condition ☐Tuberculosis
☐Anemia ☐Cancer ☐Glaucoma ☐Liver Disease ☐Arthritis
☐Hay Fever ☐Sinus ☐Asthma ☐Stroke ☐Hepatitis
☐Renal Failure ☐CHF ☐COPD
☐Diabetes Insulin: ☐Yes ☐No
☐Other: _____

Currently being treated for:

Current Medications Prescription & Over the Counter	Dosage Frequency	Located

Turn over for more information

Name of Doctor:	Phone #:
Name of Doctor:	Phone #:
Name of Doctor:	Phone #:
Allergies to Medications:	

LAST HOSPITALIZATION

Hospital:

Location: Year:

☐MOLST/DNR	☐Organ Donor

INSURANCE COVERAGE

☐Blue Cross # _____ ☐Blue Shield # _____

☐Medicare # _____ ☐Medicaid # _____

☐Other: _____ Policy # _____

IN CASE OF AN EMERGENCY, NOTIFY:	
1. Name:	Relationship:
Address:	
City, State, Zip:	Phone #
2. Name:	Relationship:
Address:	
City, State, Zip:	Phone #
3. Name:	Relationship:
Address:	
City, State, Zip:	Phone #