Emergency Medical Information

Fill out this form completely, print it and put it somewhere easy for emergency services to find. Don't forget to update this form if any of your information changes.

Name: ______________________

Date Completed:

____/____/______

Date of Birth: ______________________

Phone Number: ______________________

Address: ______________________

Street Town State Zip Code

Preferred Hospital*: ______________________

In the case your condition is unstable, or you require specialty services, the EMS crew may suggest an alternative destination to better suit your emergency. If you are incapacitated, the crew will use their best judgement for hospital choice, taking into mind your preferred destination hospital.

Emergency Contact #1

Name: ______________________

Relationship: ______________________

Phone Number: ______________________

Emergency Contact #2

Name: ______________________

Relationship: ______________________

Phone Number: ______________________

Primary Insurance

Name: ______________________

Policy #: ______________________

Secondary Insurance

Name: ______________________

Policy #: ______________________

Past Medical History:

☐ Diabetes ☐ Stroke/CVA/TIA ☐ Asthma/COPD ☐ Seizures ☐ Pacemaker

☐ Hypertension ☐ Cancer: ________ ☐ Heart Attack ☐ Hearing Aids ☐ DNR

Other Medical History: ______________________

Medications:		

Allergies: ______________________