Name:_____
Address:_____
City:_____State:____Zip:_____
Date of Birth:_____ Sex: Male Female
Weight:_____ Height:_____ Hair/Eye color____/_____
In case of emergency contact:
Name & Phone:_____( )_____
Name & Phone:_____( )_____
Physician name and phone number: _____
_____( )_____
Hospital Preference:_____
Have you been a patient there before?_____
Insurance:_____

Medical Conditions:
_____
_____
_____
_____
Do you carry an Epi Pen? _____
Current Medications: (Name & Dose)
_____
_____
_____
_____
_____
Are any of the above blood thinners?_____

Allergies to Medications_____
Other Allergies_____
_____
_____
Blood Type:_____
Do you have a pacemaker?_____
Do you have a Living Will?_____
Do you wish to be an organ donor?_____
DNR (Do Not Resuscitate)

Do you wear contacts?_____
Signature_____
Date completed_____
Dates updated_____
_____
_____
_____
_____

Disclaimer: this is correct to the extent of my knowledge. This is for emergency care first aid and not admission to a facility.
(Rev. 2013 08)

Name:_____
Address:_____
City:_____State:____Zip:_____
Date of Birth:_____ Sex: Male Female
Weight:_____ Height:_____ Hair/Eye color____/_____
In case of emergency contact:
Name & Phone:_____( )_____
Name & Phone:_____( )_____
Physician name and phone number: _____
_____( )_____
Hospital Preference:_____
Have you been a patient there before?_____
Insurance:_____

Medical Conditions:
_____
_____
_____
_____
Do you carry an Epi Pen? _____
Current Medications: (Name & Dose)
_____
_____
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_____
_____
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Are any of the above blood thinners?_____

Allergies to Medications_____
Other Allergies_____
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