EMERGENCY MEDICAL INFORMATION FORM

THIS DOCUMENT WILL REMAIN CONFIDENTIAL AND WILL ONLY BE SUBMITTED TO EMS IN THE EVENT OF AN EMERGENCY.

First
Name_____LastName_____
Address _____City_____St._____ Zip_____
Home Phone _____Business Phone _____ Birth Date _____
Emergency Contact
Name_____Phone_____Relationship_____
Age_____ Weight:_____
Medications presently using: (Prescribed /OTC meds) _____
_____
Medical Allergies
_____
Past Medical History: (explain)
_____
High Blood Pressure: yes/no Diabetes: yes/no Heart Disease:
yes/no Asthma: yes/no Other:
_____
Blood Type _____ Contact Lenses _____
Do you have hospitalization insurance? YES _____ NO_____ (If the answer is yes, please complete the following)
COMPANY: _____
GROUP# _____
POLICY# _____
CONTACT PHONE _____
PARTICIPANTS SIGNATURE _____ DATE _____