

EMERGENCY MEDICAL INFORMATION

FOR FIRST RESPONDERS

Full Name:

Date of Birth:

Age:

Sex

Blood Type:

Medical Conditions (check all that apply):

Afib	Aids	Alcohol Addiction	Arthritis	Asthma/ COPD	Bipolar
Blood Thinners	Cancer	Cataracts	Clotting Disorder	Crohns	Dementia
Depression	Diabetes	Drug Addiction	Gout	Heart Condition	Hepatitis
High Blood Pressure	Kidney Disease	Kidney Stones	MRSA	Osteoporosis	Ostomy
Pace maker	Seizure	Stroke	STD	TB	UTI

Current Medications:

Allergies:

No Know Allergies

Medications _____

Food _____

Latex Yes No

Other _____

Reaction Type:

Primary Emergency Contact:

Name:

Relationship:

Phone:

Secondary Emergency Contact

Name:

Relationship

Phone:

Primary Physician

Name:

Phone:

Additional Emergency Notes (Anything First Responders should know immediately)

Consent Statement

Name _____ Signature _____