CONFIDENTIAL EMERGENCY MEDICAL FORM

(Keep this form in your possession)

Please follow these instructions: Fill out this form and place it inside a sealed envelope.
Put your name on the outside of the envelope and place in a conspicuous location in your hotel room.

PLEASE PRINT

First Name: ______________________ Last Name: ______________________

Address: ____

City: ______________________ State: ______________ Zip Code: __________

Telephone #: (Home) ______________________ (Cell. Phone #) ______________________

1st Emergency contact NAME: ______________________ Relationship: ______________

Telephone #: (Home) ______________________ (Cell. Phone #) ______________________

2nd Emergency contact NAME: ______________________ Relationship: ______________

Telephone #: (Home) ______________________ (Cell. Phone #) ______________________

Medication allergies: ____

Other allergies: ____

DOB: ______________ Weight: ______________ Height: ______________

Primary Care Physician Name: ____

City and State: ____

Phone #: ______________________

Health problems/conditions ____

____

Other physicians:

Name ______________________ Name ______________________

Specialty ______________________ Specialty ______________________

City and State ______________________ City and State ______________________

Phone # ______________________ Phone # ______________________

Date of last tetanus shot ______________

Current prescription medications:

Name of medicine	Dose	How Often	Reason

Over-the-counter medications

Name of medicine	Dose	How Often	Reason

Previous surgeries:

What	When

Do you have any of these conditions?

Difficulty with anesthesia?	YES	NO
Past blood transfusion?	YES	NO
Do you wear glasses or contact lenses?	YES	NO
Do you wear dentures or partial plate?	YES	NO
Do you have difficulty hearing?	YES	NO
Do you smoke? If so, how much?	YES	NO
Have you been out of the country in the past 6 months?	YES	NO
Do you have a living will/durable power of attorney for health care?	YES	NO

Any other information Emergency Room physician should know about you? (please use back of form)

Insurance Plan: ______________________________

Group #: ____________________ Member's #: ____________________

Phone # ____________________

I authorize release of this information in a medical emergency to an EMT and/or Emergency Room Physician:

____________________ ____________________

Signature Date