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