THE NATIONAL FRATERNITY OF
THE SECULAR FRANCISCAN ORDER
CONFIDENTIAL EMERGENCY MEDICAL FORM

Name: _____

Address: _____

Telephone Home: ( ) _____ Work: ( ) _____

Next of kin: _____

Address: _____

Telephone Home: ( ) _____ Work: ( ) _____

In case of emergency notify: _____ Relation: _____

Address: _____

Telephone Home: ( ) _____ Work: ( ) _____

Medication allergies: _____

_____

Other allergies: _____

_____

DOB: _____ Weight: _____ Height: _____

Primary Care Physician Name: _____

Address: _____

Phone: ( ) _____

Health problems / conditions: _____

_____

_____

Specialty / other physicians:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: ( ) _____ Phone: ( ) _____

Specialty: _____ Specialty: _____

Date of last tetanus shot: _____

Current prescription medications:

Name	Dose	How often	Reason

~ BE SURE TO FILL OUT THE OTHER SIDE OF THIS FORM ~

Over the counter medications:

Name of medicine	Dose	How often	Reason

Previous surgery:

What	When

Yes _____ No _____ Difficulty with anesthesia?
Yes _____ No _____ Past blood transfusion?
Yes _____ No _____ Do you wear glasses / contacts?
Yes _____ No _____ Do you wear dentures / partial plate?
Yes _____ No _____ Do you have difficulty hearing?
Yes _____ No _____ Do you smoke? How often? _____
Yes _____ No _____ Have you been out of the country in the past 6 months?
Yes _____ No _____ Do you have a Living Will / Health Power of Attorney?
(Make sure family members know the location of these documents.)

Is there any other information that you think an Emergency Room physician should know about you?

_____

_____

_____

Insurance information:

Plan: _____

Group #: _____ Other #: _____

Phone: ( ) _____

I authorize the release of this information in a medical emergency to an EMT and/or Emergency Room physician.

The above is accurate as of

_____ _____

Signature Date

NOTE: PLACE THIS FORM INSIDE AN ENVELOPE AND SEAL IT. PUT YOUR NAME ON THE OUTSIDE OF THE ENVELOPE AND PLACE IN A CONSPICUOUS LOCATION IN YOUR ROOM.