

# In Case of An Emergency

Date Form Completed: \_\_\_\_\_ Current Age: \_\_\_\_\_

## **INFORMATION IS FOR:**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Blood Type: \_\_\_\_\_

Medications Allergic To: (See Below)

## **EMERGENCY PHONE NUMBERS** (besides 911):

Fire: \_\_\_\_\_

Police: \_\_\_\_\_

Ambulance: \_\_\_\_\_

Hospital: \_\_\_\_\_

**DIRECTIONS-** To provide Emergency Personnel *directions to your home*:

Subdivision or Condo Association: \_\_\_\_\_

Nearest Intersections: \_\_\_\_\_

Nearest Major Roads: \_\_\_\_\_

## **OTHER PERSONAL INFORMATION:**

Date of Birth: \_\_\_\_\_

House Number \_\_\_\_\_

Street: \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Driver's License # \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Eyes: \_\_\_\_\_

Pacemaker: ( ) yes ( ) no

Eye Glasses: ( ) yes ( ) no

Contact Lens: ( ) yes ( ) no

False Teeth: ( ) yes ( ) no

Birthmarks or Scars/Where: \_\_\_\_\_

## **PHYSICIAN(s):**

Primary Care Doctor \_\_\_\_\_

City/State: \_\_\_\_\_

Telephone Number \_\_\_\_\_

Emergency Service \_\_\_\_\_

Specialist (identify) \_\_\_\_\_

City/State: \_\_\_\_\_

Telephone Number \_\_\_\_\_

Emergency Service \_\_\_\_\_

## **HOSPITAL(s):**

Name the *preferred hospital* or one covered by your insurance

\_\_\_\_\_

If necessary transport me to the following hospital:

\_\_\_\_\_

**INSURANCE:**

**Primary**

Carrier (i.e. Prudential etc) \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Pre-Certification Phone: \_\_\_\_\_

**Secondary** (Medicaid, Medicare, etc.)

Carrier \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Pre-Certification Phone: \_\_\_\_\_

**EMERGENCY CONTACT(s):**

Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Phone Number \_\_\_\_\_

Cell Phone/Pager \_\_\_\_\_

Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Phone Number \_\_\_\_\_

Cell Phone/Pager \_\_\_\_\_

**OTHER PERTINENT DOCUMENTS/INFORMATION:**

If applicable, attach document to this sheet

Living Will  yes  no

Do Not Resuscitate  yes  no

Organ Donor:  yes  no

**Medical Power of Attorney:**

Person Designated: \_\_\_\_\_

Telephone Number \_\_\_\_\_

Cell Phone/Pager # \_\_\_\_\_

**CHRONIC MEDICAL CONDITION(s):**

(Identify, i.e. Huntington's Disease, Cancer, Congestive Heart Failure, Diabetic I or II, Emphysema, Epilepsy, Seizures, Kidney or Liver disease etc.)

Condition: \_\_\_\_\_

Diagnosed: \_\_\_\_\_

Specialist: \_\_\_\_\_

Condition: \_\_\_\_\_

Diagnosed: \_\_\_\_\_

Specialist: \_\_\_\_\_

**OTHER MEDICAL CONDITIONS:**

(Identify i.e. Hearing Loss, Blind, Anemia, Thyroid Disease, High Blood Pressure, etc.)

Condition: \_\_\_\_\_

Diagnosed: \_\_\_\_\_

Specialist: \_\_\_\_\_

Condition: \_\_\_\_\_

Diagnosed: \_\_\_\_\_

Specialist: \_\_\_\_\_

**VACCINATIONS -** Year of last vaccination:

Tetanus/diphtheria \_\_\_\_\_

Pneumococcal vaccine \_\_\_\_\_

Flu vaccine \_\_\_\_\_

Measles, mumps, rubella \_\_\_\_\_

Polio \_\_\_\_\_

Varicella (chickenpox) \_\_\_\_\_

Hepatitis A \_\_\_\_\_

Hepatitis B \_\_\_\_\_

**ALLERGIC TO - DO NOT GIVE:**

(list everything i.e. Morphine causes rash, etc.)

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

**SPECIAL INSTRUCTIONS:**

*Identify* i.e.: Keep Calm/Tends To Hyperventilate When Excited-Seizure Prone;  
Do Not Use Restraints; Keep Head Elevated/Swallowing Difficulties, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATION(s):**

List or use the Medication Form and say "See Attached"

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL CONTACTS:** (To Be Made By Family, **Not** EMS, i.e. employer, other emergency contacts, funeral homes, clergy, etc.)

Organization: \_\_\_\_\_

Person To Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Organization: \_\_\_\_\_

Person To Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Organization: \_\_\_\_\_

Person To Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

**THIS PERSON IS UNDER AGE 18**

This form is for my child, under age 18. Permission is granted to treat my child in an emergency  
( ) Yes. ( ) No, contact me prior to treating.

Parent Name: \_\_\_\_\_

Emergency Telephone Number: \_\_\_\_\_

Signature: \_\_\_\_\_