

MEDICAL INFORMATION

Date Completed _____

First Name			Middle / Initial			Last Name		
Street Address					City		Zip	
Date of Birth	Age	Male / Female	Height	Weight	Hair Color	Eye Color		
Phone Number				Physician Name / Phone Number				
Emergency Contact / Phone Number				Emergency Contact / Phone Number				
Current Medical Conditions:								
Heart	Cancer	Stroke	Seizures	Diabetes	Asthma	Blood Pressure ____ High ____ Low	Pacemaker	Defibrillator
Blood Type	Other Special medical issues:							
Current Medications, include dosage and frequency:								
Allergies to Medications:								
Last Hospitalization:								
Special Instructions (such as health directives, etc):								
Health Insurance Policy:								
Any additional information you would like to share:								

INSTRUCTIONS: Make additional copies of this form in the event you need to update it.

Complete the form and place 2-copies in an envelope labeled ***MEDICAL INFORMATION***. Secure the envelope to your refrigerator door. You may want to include a picture of yourself. Be sure to keep it at eye level so that it is easily visible to First Responders.

Label one of the copies for the First Responders to take- this will be useful in transport and at the hospital.

Remember to update the information as it changes.