Emergency Medical Information

Complete and insert form into envelope. Place envelope on the front of your refrigerator. Your participation will provide emergency personnel with immediate access to your vital medical information.

Name ______________________ Date of Birth ______________________

Address/Zip Code ____

Emergency Contact ______________________ Relationship______________________

Address/Zip Code ____

Doctor's Name ______________________ Doctor's Phone ______________________

Preferred Hospital ____

Important Medical Information

Check if you are being treated for, or have a history of:

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Low blood Pressure
- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ Speech Impairment

List any other medical conditions you have. ____

____

____

What medications are you presently taking?____

____

____

Do you wear contact lenses?	☐ Yes	☐ No
Do you have a "Living Will"?	☐ Yes	☐ No
Do you have a pacemaker?	☐ Yes	☐ No
Do you have false teeth?	☐ Yes	☐ No

Any Other information deemed important: ____

____

____