Emergency Medical Information

SCPD Emergency Preparedness Committee

Name _____ Date _____

Address _____ Phone _____

Birthdate_____ Sex____ Ht_____ Wt____ Hair color_____ Eye color_____

Primary Physician _____ Phone _____

Specialist Physician _____ Phone _____

Insurance: Primary _____ Secondary _____

Include copies, front and back, of your insurance cards.

Preferred Hospital _____ Preferred Pharmacy _____

Phone _____ Phone _____

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Person to Contact in Case of Emergency _____

Relationship _____ Phone _____

Out of State Contact _____ State _____ Phone _____

Special Instructions such as health directives, etc. _____

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MEDICAL INFORMATION

☐ Deaf	☐ Blind	**Please check the appropriate box if you have any of the following:**	
☐ Contact Lenses	☐ Pacemaker	☐ Dentures	☐ Hearing Aid(s)
☐ Heart Ailment	☐ Cancer	☐ One Kidney	☐ Kidney Dialysis
☐ High Blood Pressure	☐ Diabetes	☐ Stroke	☐ Epilepsy
☐ Low Blood Pressure	☐ Respiratory Problems	☐ Blood Disorder	☐ Emphysema
☐ Sickle Cell Trait	☐ Aneurysm	☐ Artificial Limb	☐ Metal Prosthesis

Allergies (esp. to medications) _____

Other / Surgeries

Medication	Generic Name	Dosage	Prescribing MD	How Long Used

MDD3.6
Author: JG

Revised by: SE
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