EMERGENCY MEDICAL INFORMATION FORM

THIS DOCUMENT WILL REMAIN CONFIDENTIAL AND WILL ONLY BE SUBMITTED TO EMS IN THE EVENT OF AN EMERGENCY.

First Name_____ Last Name_____

Address _____City_____St._____ Zip _____

Home Phone _____Business Phone _____ Birth Date _____

Emergency Contact Name_____Phone _____Relationship_____

Age_____ Weight:_____

Medications presently using: (Prescribed /OTC meds) _____

_____

Medical Allergies _____

Past Medical History: (explain) _____

High Blood Pressure: yes/no Diabetes: yes/no Heart Disease: yes/no Asthma: yes/no Other:

_____

Blood Type _____ Contact Lenses ____

Do you have hospitalization insurance? YES _____ NO_____ (If the answer is yes, please complete the following)

COMPANY: _____

GROUP# _____

POLICY# _____

CONTACT PHONE _____

PARTICIPANTS SIGNATURE _____ DATE _____