

EMERGENCY INFORMATION

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

MEDICAL CONDITIONS: _____

ALLERGIES: _____

MEDICATIONS: (please write any additional medications on back)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

ANY IMPLANTED DEVICES: _____

MEDICAL AIDS (dentures, glasses, etc): _____

INSURANCE: _____ HOSPITAL PREFERENCE: _____

EMERGENCY CONTACT: _____ PHONE: _____

MEDICAL INFORMATION:

DO YOU HAVE A LIVING WILL? YES NO If yes, where is it located? _____

DO YOU HAVE A DNR? YES NO If yes, where is it located? _____

INFORMATION ON HANDLING YOUR PERSONAL AFFAIRS

WHO SHOULD WE LEAVE HOUSE KEY WITH? _____

DO YOU HAVE CHILDREN WHO LIVE AT HOME? YES NO

EMERGENCY CAREGIVER FOR CHILDREN: _____ PHONE: _____

CHILD'S MEDICAL INFORMATION: _____

DO YOU HAVE PETS AT HOME? YES NO HOW MANY? _____

EMERGENCY CAREGIVER FOR PETS: _____ PHONE: _____

PET CARE, FEEDING, MEDICATION INSTRUCTIONS: _____

VETERINARIAN CONTACT: _____