



Emergency Medical Information Card

Date Completed/Updated: _____

Name: _____ Date of Birth: _____ Age: _____

SSN #: _____ Phone Number: _____

Primary Residence: _____
Address City State Zip Code

Emergency Contact (Guardian if under 18):

Name & Relation: _____ Phone Number: _____

Preferred Hospital: _____

Primary Physician's Name: _____ Physician's Phone: _____

Please List Any **Major** Illness, Injury or Surgery:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Please List **ALL** Allergies to Foods, Medications, Animals or the Environment:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Please include any other pertinent information into the provided envelope (DNR, Copy of Insurance Card)