



Emergency Medical Form

Print out this form and complete by hand. Keep a copy on your refrigerator (Enclose in zip-lock bag), in automobile, etc.

Name:			
Address:			
City and State:			
Date of Birth:	Month:	Day:	Year:
Medical Directives: (Circle)	Organ Donor: Yes No	DNR: Yes No	Other:
Physician:	Phone:		
Physician:	Phone:		
Other Medical Data:	Blood Type:	Weight:	Height:
Miscellaneous Information:			
Primary Medical Condition :			
Other Medical Conditions :			
Other Medical Conditions :			
Other Medical Conditions :			
Drug Allergies :			
Drug Allergies :			
Food/Insect Allergies :			
Implants, etc. :			
Hospital Name/Phone No. :			
Pharmacy Name/Phone No. :			
Previous Surgeries: :			
Previous Surgeries: :			
Previous Surgeries: :			
Lab Test: :	Results		
Lab Test: :	Results		
Other: :			

IN CASE OF EMERGENCY CONTACTS Next Page

Consent to Treat - *Optional*

Physicians and hospitals are authorized to photocopy this medical record. In case of emergency, I, _____, authorize anyone to administer first aid and Any licensed physician to render medical treatment and perform necessary surgery. When time permits, the need for major surgery must be agreed upon by two qualified physicians. The surgeon may select the anesthetist of his/her choice.

I hereby authorize any physician or hospital to furnish full information concerning my medical condition and medical history to anyone rendering medical treatment to me or my child.

Signature _____

In case of emergency, I, _____, authorize the following person/s to discuss my medical condition with physicians, hospitals and or other healthcare providers.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

This form was completed by: _____

Date completed: _____