EMF EMERGENCY MEDICAL FORM

FILL OUT AND PLACE ON FRIDGE

Date _____

PERSONAL INFO

First Name: _____

Last Name: _____

Street Address: _____

_____

City: _____

State: _____

ZIP: _____

Date of Birth: _____ Sex: _____

Height: _____ Weight: _____

Phone #: _____

MEDICAL INFO

Medical Conditions: _____

_____

_____

_____

Medications/Dosage: _____

_____

_____

_____

Blood Thinners YES ❑ NO ❑
If YES which Medication: _____

_____

Supplements: _____

_____

Allergies: _____

_____

Past Surgeries/Dates: _____

_____

_____

Preferred Hospital: _____

Primary Doctor's Name: _____

Primary Doctor's Phone #: _____

Primary Language: _____ Blood Type: _____

Do you need a Translator? YES ❑ NO ❑

Donor YES ❑ NO ❑

Hearing Aids YES ❑ NO ❑

Walker or Cane YES ❑ NO ❑

Glasses or Contact Lenses YES ❑ NO ❑

Religious Preference: _____

Do you have a Do Not Resuscitate Order (DNR)? YES ❑ NO ❑
If YES where is it Located: _____

Advanced Directives: _____

_____

_____

Additional Information and Instructions: _____

_____

_____

_____

EMERGENCY CONTACTS

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____