KDBA

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 _____Wt: _____

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 _____