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 _____

Mail to: Donna Salsman
PO Box 135
Buffalo, KY 42716

email: dsalsman1689@gmail.com

PARTICIPANTS SIGNATURE _____ DATE _____