Medical Emergency Information

Name: _____

Date of birth: _____

Doctor: _____

Phone number: _____

Emergency contacts	Phone

Health insurance

_____

ID number: _____

Emergency information location

_____

_____

Medication	Dosage	Frequency

Medical Conditions (check all that apply)

- ☐ No medical conditions
- ☐ Bleeding disorder
- ☐ Heart problems
- ☐ Hypertension (high blood pressure)
- ☐ Stroke
- ☐ Asthma
- ☐ Diabetes/Insulin dependent
- ☐ Seizure disorder
- ☐ Dehydration risk
- ☐ Constipation risk
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Allergies

- ☐ No known allergies
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Other information for emergency responders:

_____

_____

_____