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:

_____

_____

_____