EMERGENCY MEDICAL HISTORY

This form is for Emergency use when Parent/Guardian/Representative is not immediately available but the individual needs emergency medical assistance. **For use by Emergency Personnel Only.**

NAME: ________________________________ **Nickname:** ____________________
Birth Date: ____________________
Home Address: _______________________________ **Home/Work Phone:** ________
Parent/Guardian: ______________________ **Address:** ______________________
Phone Numbers: ____
Primary Language: _____________________

EMERGENCY CONTACT NAMES, RELATIONSHIP, and PHONE NUMBERS:
#1____
#2____
#3____

Physicians

Primary Care Physician: ____
Emergency Phone: __________________________ **Fax:** ______________________

Current Specialty Physician: ____
Specialty: __________________________
Emergency Phone: __________________________ **Fax:** ______________________

Current Specialty Physician: ____
Specialty: __________________________
Emergency Phone: __________________________ **Fax:** ______________________

Short Medical History

Diagnosis: ____
Current Medications (Name, Dose, Frequency given): ________________________
ALLERGIES (Drug): ____
____
____
____

ALLERGIES (Food): ____
____
____
____
____
____

Latex Allergy: Yes ______ No _____

Past Procedures (Procedure, Date, Facility):

Procedures to Avoid (and Why):

Prostheses/Appliances/Advanced Technology Devices:

Notes: