

EMERGENCY MEDICAL RECORD

Last Updated: ____ / ____ / ____

PERSONAL INFORMATION

Full Name: _____

Date of Birth: _____

Blood Type: _____

Organ Donor: Yes / No

EMERGENCY CONTACTS

Primary: _____

Phone: _____

Secondary: _____

Phone: _____

CRITICAL MEDICAL ALERTS / ALLERGIES

CURRENT MEDICATIONS

Medication Name	Dosage	Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL CONDITIONS

â–| Diabetes

â–| Hypertension

â–| Heart Condition

â–; Asthma / COPD

â–; Epilepsy / Seizures

HEALTHCARE PROVIDERS

Primary Doctor: _____

Clinic Phone: _____

Preferred Hospital: _____

Insurance Co: _____

LEGAL DOCUMENTS

DNR (Do Not Resuscitate) on file: Yes / No

Living Will: Yes / No

Healthcare Proxy: _____

Place this form in a visible location (e.g., refrigerator) for First Responders.