MEDICAL INFORMATION Date Completed_____

First Name	Middle / Initial	Last Name

Street Address	City	Zip

Date of Birth	Age	Male / Female	Height	Weight	Hair Color	Eye Color

Phone Number	Physician Name / Phone Number
Emergency Contact / Phone Number	**Emergency Contact / Phone Number**

Current Medical Conditions:

Heart	Cancer	Stroke	Seizures	Diabetes	Asthma	Blood Pressure ____High ____Low	Pacemaker	Defibrillator

Blood Type	Other Special medical issues:

Current Medications, include dosage and frequency: *(Please use the back if more space is needed)*

Allergies to Medications:

Last Hospitalization:

Special Instructions (such as health directives, etc):

Health Insurance Policy:

Any additional information you would like to share:

INSTRUCTIONS: Make additional copies of this form in the event you need to update it.

Complete the form and place 2-copies in an envelope labeled ***MEDICAL INFORMATION*.** Secure the envelope to your refrigerator door. You may want to include a picture of yourself. Be sure to keep it at eye level so that it is easily visible to First Responders.

Label one of the copies for the First Responders to take- this will be useful in transport and at the hospital.

Remember to update the information as it changes. Please email Brenda Smith at blsmith@slcfd.org to request another packet. Or for more information call 772.621.3333.

Medication Sheet

Patient Name	Allergies

Date	Medications	Frequency	
Start / Stop	Name of Medication	X Per Day	Dosage