MEDICAL EMERGENCY INFORMATION

Name: _____ **DOB:** _____ **Updated [date]:** _____

Who to call for assistance and support:
Call first: [Name & Phone Number] _____
Then call: [Name & Phone Number]
_____

Medical Conditions:	**Onset Date**

Past Surgeries:	**Surgery Date**

Drug Allergies:
NOTE: [Special precautions, special notes]

Medications: as of [date]	**Start Date**
Prescribed by Dr. [Name] [Phone #]:	
Prescribed by Dr. [Name] [Phone #]:	
Prescribed by Dr. [Name] [Phone #]:	

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Primary Care Physician: [Practice Name, Address, Phone]
Other Physicians: [Practice Name, Address, Phone]

Advance Directives:
Healthcare POA [Who, then who; Living Will]
Burial Information:
SSN [last 4 digits]: XXX-XX-XXXX
Driver's License [Name, Number, Expiration]:

Health Insurance: [Company, Policy, Subscriber ID: Group No.:]
Long Term Care Insurance: [Company, Policy #]
Contact (local):
Corporate:

Attach a page with a photocopy of both sides of Health Insurance card and Driver's license.

Attach copies of advance directives (Healthcare POA) and Living Will.

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