Emergency Medical Information Sheet

Name: ____

Last Updated: ______________________________

DOB: _________________________ SS #: _________-______-__________

Allergies:

- ____
- ____
- ____
- ____
- ____

Medications:

- ____
- ____
- ____
- ____
- ____
- ____
- ____

Past Medical History:

____

____

____

____

____

____

Weight: ___________*lbs* ______________*kgs*

Home Address: ____

____

Emergency Contact Name: _______________________ Relation: _______________

Phone #: ______-_________-_____________

** Recommend keeping this sheet in your purse, wallet, glove box, and/or refrigerator.*

** Update anytime information changes.*

Created by Claylick Fire Department 2013