In an emergency call 911 **Adult Emergency Information Form** Room # _____

Name: _____ Date of Birth: _____

Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____

Check One: Male _____ Female _____ Height: _____ Weight: _____

EMERGENCY INFORMATION

Contact Person: _____

Relationship: _____ Phone: _____

Second Contact: _____ Phone: _____

Hospital: _____ TEAM: _____

Call Doctor: _____ Phone: _____

Medical Conditions (Mark all that apply):

High blood pressure _____ Respiratory _____ Diabetes _____ Seizures _____ Pacemaker _____

Blood thinner _____ Other: _____

I am allergic to these medications: _____

I am allergic to these foods/other: _____

Medications Update:

	Medications	**Dose**	**How Often**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

REMEMBER TO UPDATE YOUR INFORMATION WHEN CHANGES OCCUR