EMERGENCY FACT SHEET

INDIVIDUAL ______________________

Attach Photo Here (optional)

Date of Birth: _____/_____/_____ **Sex:** M __ F __

Marital Status: _________________ **Religion:** ___________

Address: ____

____

Phone: (_____) ____________________________________

Guardian: _______________________ **Phone:** ___________

(if applicable)

Address: ____

Next of Kin: _______________________ **Phone:** __________

Address: ____

____

Social Security No.: _____/_____/_____ **Insurance Information:** __________________________

____

Health Care Providers: (physicians, therapists, dentist, etc.)	Service:	Phone:

Medical Problems List:

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Allergies:

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Medications: (attach medication sheet to this sheet if necessary)	Dosages:

Date of Last Tetanus Immunization: _____/_____/_____ **Date of Last MMR:** _____/_____/_____ **(if indicated)**

Date of Last Annual Physical Exam: _____/_____/_____

OVER ☞☞☞☞

EMERGENCY CONSENT FORM
(optional, but encouraged)

I hereby give consent for ______________________to receive emergency medical treatment.
(insert name of individual)

_____/_____/_____ to _____/_____/_____
(Insert period of consent)

____
Legal Guardian (Parent or Legal Guardian if under 18)

The signature here authorizes consent for emergency treatment only, not verification of information on this sheet.

Other Interested Individuals (providers, friends, etc.):

Name:	______________________	______________________
Address:	______________________	______________________
Phone:	______________________	______________________
Relationship:	______________________	______________________
Name:	______________________	______________________
Address:	______________________	______________________
Phone:	______________________	______________________
Relationship:	______________________	______________________

Other Individual Pertinent Information:

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Date Completed ❑ or Updated ❑ : _____/_____/_____

1/2004