Emergency Medical Information

_____ CODE STATUS: _____ *(DNR or full code?)*

Last name, first name

BIRTHDATE:_____ ***RUSH STUDY*** *(if applicable)*_____

Primary Care Doctor: _____ PHONE: _____

Other Doctor/Specialist:_____ PHONE: _____

Other Doctor/Specialist:_____ PHONE: _____

HEALTH HISTORY:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES: _____ **PHARMACY:**_____

Either list medications or attach a photocopy of medication list

Medication	Dose	Time

Emergency Contact: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Power of Attorney for Health Care:_____ Phone:_____

Preferred Hospital: _____

Attach a copy of insurance / Medicare cards

Date this form was completed:_____