

Emergency Information

Name: _____

Address: _____

Home Phone: () _____ Work Phone: () _____

SSN# _____ WADL# _____

Date of Birth (mm/dd/yy) _____ Age: _____ Gender: M / F

Emergency Contact:

Name: _____

Phone: () _____

City/State: _____

Relation: _____

Medical:

Family doctor/facility: _____

Address _____

Office Phone: () _____

Special Medical Conditions: _____

Current Medication(s): _____

Drug Allergies: _____

Medical Insurance: _____

Address/Phone: _____

Policy #s: _____

Second opinion req'd? Yes / No

Do you have a living will? Yes / No **Organ Donor?** Yes / No Other: _____

Religion: _____

Sign here to authorize emergency medical treatment by a Doctor, Hospital, EMT when direct authorization can not be given: _____ www.pacifictrainingservices.com

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