Emergency Medical Information

Keep originals with important papers; place copies on the fridge for emergency contacts and EMTs

Last Name	**First Name**	Initial	Phone
Address	City	State	Zip
Date of Birth	Gender ☐ M ☐ F	Height	Weight
Impairments (Check Box)	☐ Hearing	☐ Vision	☐ Speech ☐ Mobility
Primary Language		Dentures - ☐ Yes ☐ No	
DNR or **POLST** ☐ Yes ☐ No	**Healthcare Power of Attorney** ☐ Yes ☐ No		**Living Will/Advanced Directive** ☐ Yes ☐ No
Emergency contact #1	Name	Cell	Relationship
Emergency contact #2	Name	Cell	Relationship
Emergency contact 3	Name	Cell	Relationship

Allergies; Medications? Latex? Other?

Medical History, recent injuries, surgeries:

_____

_____

_____

Healthcare Insurance	Member #	Plan #	Group #	Medicare/Medicaid ☐ Yes ☐ No

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Please list all medications

Name of Medication	Dosage	Frequency/when taken
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Addition comments, history or background:		
Circle all documents attached *Keep originals with important papers*	DNR	POLST POA

VOP-I/Forms/FileforLife 6-18-2025

Patient/POA Signature **Date**