Emergency Medical Information Form

Westport Weston Health District

Date form completed: _____ **Completed by:** _____

PERSONAL INFORMATION

Name: _____ Social Security #: _____

Address: _____

Town: _____ State: _____ Zip: _____

Primary phone number: _____ Secondary phone number: _____

Sex: M F Date of birth: _____ HT: _____ WT: _____ Primary language: _____

EMERGENCY CONTACTS *(please list two)*

Name: _____ Name: _____

Relation: _____ Relation: _____

Primary phone number: _____ Primary phone number: _____

Secondary phone number: _____ Secondary phone number: _____

E-mail address: _____ E-mail address: _____

MEDICAL DATA

Primary physician: _____ **Physician phone number:** _____

Allergies: _____

Existing Medical Conditions: _____

Current Medications:

Medication Name	Dosage	Frequency	Pharmacy Phone	Prescription Number