

Emergency Medical Form

Personal Information			
First Name	Last Name	Preferred Name	Patient Identifier (If known)
Gender	Preferred Pronouns	Date of Birth	Marital Status
Address		City	State
Email		Preferred Phone Number	
Emergency Contact			
Full Name	Relationship	Contact Number	
Full Name	Relationship	Contact Number	
Medical Information			
Primary Care Physician	Address	Contact Number	
Please list any medical conditions			
Please list any current medication			
Please list any allergies			
Additional Information			
Emergency Medical Consent			
I, _____, consent to _____ authorizing medical care for _____ in the event of an emergency.			
Parent or Guardian Name (If Applicable)		Relationship to Patient (If Applicable)	
Signature of Patient, Parent or Guardian <i>A. Sample</i>		Date	