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	Zip Code

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	Date