EMERGENCY MEDICAL INFORMATION

Augusta Township Fire Department

Please place this form somewhere like on your Refrigerator or the inside of your bedroom door.
Make sure to keep the information up to date!! Updated _____

Name_____ Date of Birth_____
Address_____ City_____
Phone Number_____

Medical History:

List all of your medical history here:

- ☐ Cardiac _____
- ☐ Diabetes, Are you Insulin Dependant? Yes ☐ No ☐
- ☐ High Blood Pressure
- ☐ Breathing Problems
- ☐ Asthma
- ☐ Stroke(s)
- ☐ Other, Please Specify:

_____
_____
_____
_____
_____
_____

Medications You Take:

List All Prescription Meds you currently take

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Any Known Allergies?

☐ Yes ☐ None Known

_____ _____ _____
_____ _____ _____

Emergency Contact Information: People we could contact if needed.

1. Name_____ Phone_____
2. Name_____ Phone_____
Doctors Name: _____ Phone_____

Additional copies of this form are available on line at: http://www.augustatownship.org