Staff Medical History Form

Instructions: This form enables the first aid staff to have your medical information should you be unable to speak for yourself in an emergency. It will be kept confidential.

Last Name _____ **First Name** _____

Street address _____ **City** _____ **State** _____ **Zip** _____

Phone Numbers (Include area code)

Home: _____ **Cell;** _____

Sex **Age** **DOB** **Height** **Weight** **SSN**

Current Medical History (you may use the back)

Medications: Prescribed & Over The Counter & Vitamins (you may use the back)

Last Tetanus Shot Date / /

Allergies (Medication and/or FOOD)

Last Name	**First Name**	**Phone Name** (and area code)

Specialty Doctors

Doctors Name	Specialty	Phone
Doctors Name	Specialty	Phone
Doctors Name	Specialty	Phone

Emergency Contact Person

Last Name	**First Name**	**Phone (and area code)**	**Relationship**

Name:

Additional Medical History

Additional Medical History

Name	Dosage	Reason for taking

Please List any activities you need to be exempted to or limited for health reasons:

Permission to Treat

I give permission to any medical facility the permission to treat me should I become unable to communicate such wishes.

_____ _____/_____/_____

Signature Date