Emergency Medical Information

Personal Information

NAME_____**DATE**_____**PHONE**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

DATE OF BIRTH_____**AGE**_____**M**___**F**___**MARITAL STATUS**_____

SPOUSE_____**PHONE**_____

PHYSICAN'S NAME_____ **PHONE**_____

PRIMARY INSURANCE COMPANY_____

POLICY #_____ **GROUP #**_____

SECONDARY HEALTH INSURANCE COMPANY_____

POLICY #_____ **GROUP #**_____

Emergency Contacts

NAME_____**RELATIONSHIP**_____**PHONE**_____

NAME_____**RELATIONSHIP**_____**PHONE**_____

Medical Release

Bertram First Baptist Church is hereby authorized to take whatever action is deemed by them to be appropriate under the circumstances to provide emergency medical treatment for the individual named below, including, but not limited to the following: administer first aid, obtain services of a physician, transportation to the nearest available hospital, admit to a hospital, consent to medical treatment or surgery.

Volunteer Printed Name_____

Volunteer Signature_____**Date**_____

Allergies & Medication

LIST ALLERGIES: FOOD, MEDICINE, INSECT, OTHER

_____

_____

DATE OF LAST TETANUS _____

MEDICATIONS:

Medication Name	Frequency Taken	Dosage

ADDITIONAL MEDICAL INFORMATION

Asthma	**Yes**	**No**	**Chest/lungs**	**Yes**	**No**	**If "yes" to any, please explain:**
Ears: hearing aids	**Yes**	**No**	**Heart disease**	**Yes**	**No**	
Diabetes	**Yes**	**No**	**Pacemakers/DeFib**	**Yes**	**No**	
Dentures/Bridge	**Yes**	**No**	**Other**	**Yes**	**No**	

Describe other significant/chronic medical issues: _____

_____

_____

_____