My Emergency Information

My Name _____

My Phone Home _____ Cell _____

My 911 Address _____

My Mailing Address _____

My Primary Care Dr. _____

Hospital Choice _____

First Contact: Name _____

Phone _____

Relation to you _____

Second Contact: Name _____

Phone _____

Relation to you _____

Third Contact: Name _____

Phone _____

Relation to you _____

Allergies _____

_____

Other medical information that would be
hospital or EMS personnel to have in case of an

_____

_____

My Power of Attorney is: _____

Phone _____

Relation to you _____

My Medical Power of Attorney is: _____

Phone _____

Relation to you _____

Birthday _____ _____ _____

Month Day Year

Do you have an advance directive? Yes ___ or No _____

If your answer is NO, do you wish to have one? Yes ____