EMERGENCY MEDICAL INFORMATION

BECAUSE EVERY SECOND COUNTS!

SPONSORED BY: TALLAHASSEE FIRE PROTECTION DISTRICT

DATE COMPLETED: _____	UPDATED: _____ _____ _____ _____ _____

BASIC & IDENTIFYING INFORMATION

Name: _____ **Phone:** _____

Address: _____ **DOB:** _____

Male/Female	Height	Weight	Hair Color	Eye Color	Blood Type	Religion

Hearing Aid		Deaf		Blind		Artificial Eye		Glasses		Contact Lenses		Dentures/Bridge		Unable to Speak
Left	Right	Left	Right	Left	Right	Left	Right	Yes	No	Yes	No	Upper	Lower	☐

Primary Language Spoken: _____ **Other Language(s):** _____

Normal Blood Pressure: ____/____ **Smoker:** ☐ **Non-Smoker:** ☐

Are you currently taking blood thinner medication? **Yes:** ☐ **No:** ☐

Pacemaker Model #: _____ **Defibrillator Model #:** _____

Artificial Limbs or Prosthetic Devices: _____

Identifying Marks (i.e., birthmarks, tattoos, etc.): _____

EMERGENCY CONTACTS

Name #1: _____ **Phone:** _____

Address: _____

Relationship: _____

Name #2: _____ **Phone:** _____

Address: _____

Relationship: _____

MEDICAL HISTORY

Please check all that apply:

☐ Allergies	☐ Cancer	☐ Glaucoma	☐ Leukemia	☐ Stroke
☐ Alzheimer's	☐ Clotting Disorder	☐ Heart Condition	☐ Lymphomas	☐ Tuberculosis
☐ Anemia	☐ COPD	☐ Hemodialysis	☐ MyastheniaGravis	☐ _____
☐ Angina	☐ Coronary Bypass	☐ Hepatitis _____	☐ Renal Failure	☐ _____
☐ Arthritis	☐ Dementia	☐ Hypertension	☐ Seizure Disorder	☐ _____
☐ Asthma	☐ Diabetes/Insulin	☐ Hypoglycemia	☐ SickleCellAnemia	☐ _____
☐ Bleeding Disorder	☐ Epilepsy	☐ Jaundice	☐ Sinus Issues	

Please be sure to complete the reverse side. ---------->

ALLERGIES

☐ No Known Allergies	☐ Codeine	☐ Insect Stings	☐ Morphine	☐ Sulfa
☐ Aspirin	☐ Demerol	☐ Latex	☐ Novocaine	☐ Tetracycline
☐ Barbiturate	☐ Horse Serum	☐ Lidocaine	☐ Penicillin	☐ X-Ray Dyes
☐ Environmental:			☐ Other:	

CURRENT MEDICAL INFORMATION

Name of Doctor: _____ **Phone:** _____

Name of Doctor: _____ **Phone:** _____

Currently Being Treated for: _____

_____

Current Medications:

Medication	Dosage	Taken How Often? (Frequency)	Taken to Treat What Condition?	Located Where In Your Home?

Attach and date a separate page for additional medications or to record updates.

Allergies to Medications: _____

_____

HOSPITAL INFORMATION

Hospital Preference: _____ **City:** _____ **State:** _____

Last Hospitalization At: _____ **Treated For:** _____ **Date:** _____

☐ Living Will — **Location of Living Will:** _____

☐ Healthcare Proxy — **Location of Healthcare Proxy:** _____

☐ Do Not Resuscitate (DNR) Order — **Location of DNR Order:** _____

☐ Organ Donor

MEDICAL INSURANCE INFORMATION

Medicare #: _____ **Medicaid #:** _____

Other Medical Insurance Company: _____ **Policy #:** _____

Other Medical Insurance Company: _____ **Policy #:** _____

Air Medical Emergency Transport Coverage Provided By: _____

To print additional EMI Forms, go to the TFPD Website: WWW.TALXFIRE.COM. In the MAIN MENU, Hover over "COMMUNITY INFO" -- Then Click on "EMERGENCY MEDICAL INFORMATION PROGRAM" OR call 800-316-8233 with any questions or concerns.