DELTA COUNTY AMBULANCE DISTRICT

DIAL 9 - 1 - 1 FOR EMERGENCIES

Use pencil. Keep information up to date.

Phone # 874-9701

Personal Information

Name:	Sex: M F	
Address:	Home Phone:	Cell:
SSN:	Date of Birth:	

Emergency Contact

Name:	Home Phone:	Cell:
Address:	Work Phone:	
	Relation:	
Name:	Home Phone:	Cell:
Address:	Work Phone:	
	Relation:	

Power of Attorney

Name:	Home Phone:	Cell:
Address:	Work Phone:	
	Relation:	

Religion:

Living Will on file at:

DNR

Do you have a Do Not Resuscitate form?

Yes: No:

Where is it located?

Medical Insurance

Med Ins Co:

Policy #:

Other Med Ins Co:

Policy #:

Medicaid #:

Medicare #:

Last updated: Month Year:

Doctor:	Phone:
Doctor:	Phone:
Doctor:	Phone:

Blood Type:

Other:

Medical Conditions

Check all that exist:

( ) No known medical conditions
( ) Abnormal EKG
( ) Adrenal Insufficiency
( ) Angina
( ) Asthma
( ) Bleeding Disorder
( ) Cardiac Dysrhythmia
( ) Cataracts
( ) Clotting Disorder
( ) Coronary Bypass Graft
( ) COPD
( ) Dementia ( ) Alzheimers
( ) Diabetes / Insulin Dependent
( ) Eye Surgery
( ) Glaucoma
( ) Hearing Impaired
( ) Hemodialysis
( ) Hemolytic Anemia
( ) Hypertension
( ) Hypoglycemia
( ) Leukemia
( ) Lymphomas
( ) Memory Impaired
( ) Pacemaker
( ) Renal Failure
( ) Seizure Disorder
( ) Sickle Cell Anemia
( ) Stroke
( ) Vision impaired
( ) Other: ________
( ) Other: ________
( ) Other: ________
( ) Other: ________
( ) Other: ________

Allergies

( ) Aspirin
( ) Barbiturates
( ) Codeine
( ) Demerol
( ) Environmental
( ) Horse Serum
( ) Insect stings
( ) Latex
( ) Lidocaine
( ) Morphine
( ) Novocaine
( ) Penicillin
( ) Sulfa
( ) Tetracycline
( ) X-Ray Dyes
( ) No Known Allergies
( ) Other: ________
( ) Other: ________

Medications

Medication	Dose	Frequency	Reason

Recent Surgery: ________

Date: ________

Other: ________