"GRAB & GO" EMERGENCY DOCUMENTATION IF YOU ARE LIVING ALONE

Please complete this section with your personal information in case of your own medical emergency.

Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Date of Birth _____ /_____ / 19_____ SSN _____-_____-_____

Primary Care Physician Name _____

Primary Care Physician Contact Information _____

Health Care Proxy Contact Information

Name _____ Relationship _____

Contact Phone Number _____ Alt. Phone Number _____

Alternate Emergency Contact

Name _____ Relationship _____

Contact Phone Number _____ Alt. Phone Number _____

Do you have an Advanced Healthcare Directive? YES / NO (if YES, please attach copy)

Current Medication List (dosage, frequency, administration time)

1) 2)

3) 4)

5) 6)

Vaccinations

_____

_____

_____

Medication Sensitivities/Allergies

_____

_____

_____

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Recent Hospitalizations and Additional Medical Information (e.g. implanted devices, pacemaker, etc.)

ADDITIONAL MEDICAL INFORMATION

PET INFORMATION AND POINT OF CONTACT FOR PET CARE

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