Affix Your
Picture Here

EMERGENCY INFORMATION

Name:____ **Date:**__D__/__M__/__Y__

Address: ____

Date of Birth:___D___/___M___/___Y___ **Health Card #**__________________________

Blood Type: _______ **Height:** ________ **Weight:** _________kg

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Doctor's Name:__________________________ **Phone #:**(____) ____-__________

Emergency Contact Name:____

Home/Cell #:____

Business #:____

Relationship:__________________________

Address: ____

____

Existing Medical Conditions (Check all that apply):

Heart:

- O Angina
- O CHF
- O Heart Attack (MI)
- O Pacemaker
- O Implanted Defibrillator
- O High Blood Pressure
- O Low Blood Pressure
- O Stroke
- O TIA

Lungs:

- O Asthma
- O Emphysema
- O Bronchitis
- O Smoker

Other Medical History:

- O Alzheimer's
- O Aneurysm
- O Epilepsy
- O Glaucoma
- O Diabetes (O Diet O Meds)
- O Cancer (Location:_______________________________)
- O Other____
- O Haemophilia
- O Kidney
- O AIDS/HIV
- O Confusion/Dementia
- O Dialysis
- O Hepatitis
- O Anemia

OVER ➔

Medication (Include herbal and non-prescription):

Name	Dose	Times taken per day

Allergy to Medications:

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Documentation:

○ Do Not Resuscitate Confirmation Form (signed original)

Location:_______________________________________

○ Nursing Notes

Location:_______________________________________

Other Consideration/Disabilities:

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Please keep this information up to date

Visit www.hamilton.ca/CityDepartments/EmergencyServices/EMS for additional forms