



Plains Community Ambulance– Emergency Information Form

Fill out this form for each member of your family and post in an easily found place like the side of your refrigerator.

REMEMBER: Call 911 for emergencies!
Call your local ambulance or fire station only for routine questions

Name: _____	Age: _____
Address: _____	Zip: _____
Phone Number: _____	Birthdate: _____
Physician(s) Name: _____	S S N # : _____
Hospital of Choice: _____	Policy #: _____
Insurance Carrier: _____	Group #: _____

Medications (list only Current Medications)	For:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____

Past Medical History (Check All That Apply):

- | | | | |
|--|-----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Bypass Surgery (<input type="checkbox"/> X3 <input type="checkbox"/> X4) | | | |
| <input type="checkbox"/> Implanted Defibrillator | | | |

Other: _____

Persons to be notified in an emergency:

Name	Home Ph	Work Ph	Cell Ph	Relation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you have a signed DNR or durable medical power of attorney? If so, attach a copy to this page and include instructions for rescue workers on how to obtain the original.

(EMS cannot honor DNRs or Powers of Attorney without the original documents)

Other Comments: _____
