MEDICAL INSURANCE

This information is optional

Medicare	Yes ☐	No ☑
Medicaid	Yes ☐	No ☑
Other Medical Insurance	Yes ☑	No ☐

PHYSICIANS

Name	
Address	
City	State
Office Phone	
Name	
Address	
City	State
Office Phone	

The participant voluntarily provides their medical information, and authorizes the disclosure to, and use of, the medical information by emergency responders and other responders for the purpose of offering assistance when involved in an incident.

FAIRFIELD GLADE RESIDENT SERVICES

www.FGRServices.org

EMERGENCY MEDICAL INFORMATION

Participant's Name

Please Note: The FGRS Vial of Life program acts as a facilitator only, and all information provided on this medical information form is the sole responsibility of the participant.

KEEP YOUR INFORMATION CURRENT

Today's Date _____

Name

Address

City/State/Zip

○ M ☐ F Date of Birth Blood Type

EMERGENCY CONTACTS

Name/Relation

Address

City/State/Zip

Home Phone

Work Phone

Mobile Phone

Name/Relation

Address

City/State/Zip

Home Phone

Work Phone

Mobile Phone

LIST MEDICAL CONDITIONS AND RECENT SURGERIES:

_____

_____

_____

_____

_____

LIST ANY ALLERGIES:

_____

_____

_____

_____

_____

HOSPITAL PREFERENCES:

(does not guarantee transport to preference hospital)

1. _____
2. _____
3.

OTHER

☐ Home: Over the Counter Medications, Vitamins, and Supplements

_____

_____

_____

Do you wear contact lenses? Yes ☐ ☐ No

Have an Advance Directive? Yes ☐ ☐ No

POST Order Form? Yes ☐ ☐ No

CURRENT MEDICATIONS

☐ NO Medications

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medications (Continued)

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medications (Continued)

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

NOTES

_____