

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 Yellow DOT Program acts as a facilitator only, and all information provided on this medical information form is the sole responsibility of the participant.

Copy this form or download at www.tn.gov/tdot/yellowdot/

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. _____

CURRENT MEDICATIONS

- NO Medications
- Home: Over the Counter Medications, Vitamins, and Supplements
- _____

CURRENT MEDICATIONS CONTINUED

Prescriptions

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____

Medication _____

Dosage _____

Times Per Day _____

Reason _____