

Emergency Contacts

Name _____

Relation _____

Phone _____

Alt. Phone _____

Address _____

City _____

State/Zip _____

Name _____

Relation _____

Phone _____

Alt. Phone _____

Address _____

City _____

State/Zip _____

Name _____

Relation _____

Phone _____

Alt. Phone _____

Address _____

City _____

State/Zip _____

Important Information _____

EMERGENCY INFORMATION SYSTEM

This medical form is designed to supply first responders with critical information about you during an emergency, when you might not be able to communicate yourself.

Participation is voluntarily and authorizes the disclosure to and use of, your medical information by first responders for the purpose of offering assistance when involved in an accident.



970-824-9411

750 Hospital Loop Craig, CO

memorialregionalhealth.com



Yellow Dot Program



Medical Information Form

Photo of Participant

This is important for quick identification

Name _____

Answers to _____

Primary Language _____

Yellow Dot Program

This program acts as a facilitator only. All information provided on this form below is your sole responsibility. Please update as needed.

Request additional copies of this form from:
sheli.steele@memorialrh.org

PARTICIPANT

Name _____

Address _____

City _____

State/Zip _____

Male Female

Date of birth _____

Blood type _____

PRIMARY PHYSICIAN INFORMATION

Name _____

Phone _____

Address _____

City _____

State/Zip _____

MEDICAL HISTORY

Knowing your history is not only important to the type of care you can receive, but also could explain symptoms that you may be showing.

- No known conditions
 - HIV
 - Parkinson's Disease
 - Dementia/ Alzheimer
 - Impaired Hearing
 - Blood Clotting Disorder
 - Asthma
 - CHF
 - Heart Disease
 - Pacemaker
 - Diabetic
 - Impaired Vision
 - COPD
 - Seizures
 - Cancer of _____
 - Medication Delivery Port
 - Other: _____
- _____
- _____
- _____
- _____
- _____
- _____

Surgeries:

Allergies:

Medications: (name and dosage)

None
