BLUFFTON TOWNSHIP FIRE DISTRICT

Emergency Information Form

Date Form Completed: _________________________

Name: ____ **Phone:** __________________________

Address: ____

Date of Birth: ____________ **Gender:** ___________ **Blood Type:** ____________

Primary Care Physician: _________________________________ **Phone:** ___________________________

Emergency Contact Name: _______________________________ **Phone:** ___________________________

Medical History/Conditions: (Circle all that apply)

Alzheimer's	Clotting Disorder	Heart Failure (CHF)	Pacemaker
Angina	Dementia	Hepatitis	Pneumonia
Asthma	Diabetes	Hypertension	Rapid Heart Rate
Bleeding Disorder	Dialysis	Hypotension	Renal Failure
Bronchitis	Emphysema	Internal Defibrillator	Seizures
Chronic Illness	Heart Attack	Pacemaker	Stroke

Allergic Reaction (specify) ____

Cancer (specify) ____

Aneurysm (specify) ____

Surgeries (specify) ____

Other:____

____

Medications (please list):

NAME	DOSE	FREQUENCY

NAME	DOSE	FREQUENCY

Allergies (Including Food/Drug):

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UPDATE FORM AS INFORMATION CHANGES. FORM IS NOT USEFUL WITH OUTDATED INFORMATION.