Life Safe Emergency Information

I certify the information on this form is up to date. I also understand that emergency medical personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.

PATIENT INFORMATION

Patient Name:		Date of Birth:
Address:		Gender:
City:	Province:	Postal Code:
Telephone Number: (Home)	(Work)	(Cell)
Health Card Number:		Expiry Date:

PRIMARY MEDICAL INFORMATION

Family Doctor:		Telephone:
Address:		
City:	Province:	Postal Code:
Pharmacist:		Telephone:

HEALTH INFORMATION

Allergies to Medication:	
Other Allergies:	
Current Medications: Name/Dose	
Do you have a pacemaker? Yes ☐ No ☐	Blood Type:

MEDICAL PROBLEMS (Check all that apply)

☐ Heart Disease	☐ Stroke	☐ Epilepsy	☐ Other
☐ Cancer	☐ Diabetes	☐ Hemophilia	
☐ Asthma	☐ High Blood Pressure	☐ Seizures	

EMERGENCY CONTACT

Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:

Date Completed: ____________________ **Signature:** ____________________

Update and print your 'Life Safety Emergency Information' electronically at http://www.spid.ca/

Life Safe Medical History / Medications

Please write below any comments or instructions which would be helpful to emergency personnel in assisting you during a personal emergency. Feel free to attach a photograph of yourself so emergency personnel can match the information provided to the correct person.

ADDITIONAL INFORMATION: (Medical History/Conditions/or Advanced Directive DNR)

MEDICATIONS AND WHERE THEY ARE KEPT:

Insert Picture Here

Name (Please print)

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