



## 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personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.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 <input type="checkbox"/> No <input type="checkbox"/>	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:** \_\_\_\_\_

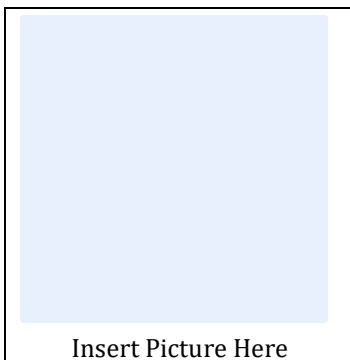


## Life Safe Medical History / Medications

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:

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Name (Please print)