WOOD DALE POLICE DEPARTMENT
Emergency Medical Form

This form will be used by first responders in case of a medical emergency at your home. Please keep this form in a place first responders will be able to find it.

Date: _____

Name (first, middle initial, last)

Address (street, city, state, zip code)

Phone number | Date of Birth | Eye color | Height | Weight | Sex | Race

Emergency Contact

Name _____ Name _____
Address _____ Address _____
Phone _____ Phone _____
Relationship _____ Relationship _____

Physicians
Dr. _____ Phone _____
Dr. _____ Phone _____
Dr. _____ Phone _____

I am currently being treated for the following conditions (please check all that apply).

☐ AIDS/HIV ☐ Cataracts ☐ Epilepsy ☐ High Blood Pressure
☐ Arthritis ☐ Diabetes ☐ Gall Bladder ☐ Kidney Problems
☐ Asthma ☐ Digestive Problems ☐ Glaucoma ☐ Mental Illness
☐ Cancer ☐ Emphysema ☐ Heart Disease ☐ Stroke
☐ Other (please list)

In the past I have been treated for:

Medications (please copy names from prescription bottles)

Where my medications are kept: _____

Allergies: _____

Blood Type | Religion | Preferred Hospital

Please keep this form visible for first responders.