Emergency Medical Information

Your Name:

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Last Updated: _______________________________

Personal Information
Full Name: _______________________________

Date of Birth: ___ / ___ / ____ Male / Female

Address: _______________________________________

City / Town: ____________________________________

Province: ______________Postal Code______________

Health Card Number: ____________________________

Home Phone: __________________________________

Cell Number: ____________________________________

Family Doctor: __________________________________

Doctor Office Phone: _____________________________

Emergency Contact Name

Phone Number:

Existing Medical Problems
Please describe below:
Heart: ______________________________________

Breathing: ______________________________________

Stroke/TIA (mini stroke): __________________________

High Blood Pressure: ____________________________

Surgeries: ______________________________________

Seizures: _____________________________________

Diabetes: ______________________________________

Psychiatric: __________________________________

Cancer: _____________________________________

Other: _____________________________________

____

Emergency Medical Information

Allergies: ____

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Do you have any regular in-home support service? Please list:

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Medication Name	Dose	What is the medication for?