Emergency Medical Form

Personal Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
John	Doe	John	00000001
Gender	**Preferred Pronouns**	**Date of Birth**	**Marital Status**
M	He/Him	01.01.1990	Married

Address	City	State	Zip Code
123 Sample Street	Sample City	AZ	12345

Email	Preferred Phone Number
johndoe@email.com	555-5555

Emergency Contact

Full Name	Relationship	Contact Number
Jane Doe	Wife	444-4444
James Doe	Son	333-3333

Medical Information

Primary Care Physician	Address	Contact Number
Dr. Smith	456 Example Street	123-4567

Please list any medical conditions
Asthma

Please list any current medication
N/A

Please list any allergies
Pollen

Additional Information
Suffered asthmatic attack during hike.

Emergency Medical Consent

I, John Doe, consent to Example Hospital authorizing medical care for myself in the event of an emergency.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)

Signature of Patient, Parent or Guardian	Date
J. Doe	6/1/2024