



# West Allis Fire Department Emergency Medical Information Sheet

Full Name \_\_\_\_\_ Date \_\_\_\_\_

DOB (MM/DD/YYYY) \_\_\_\_\_ Age \_\_\_\_\_

Social Security Number \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

### *Emergency Contacts*

_____	(_____) _____	(_____) _____	_____
Name	HM Phone	WK Phone	Relationship

_____	(_____) _____	(_____) _____	_____
Name	HM Phone	WK Phone	Relationship

### *Past Medical History*

List All Current Medical Conditions \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Primary Physician

_____	(_____) _____	_____	_____
Name	Phone	Specialty	Hospital

Current Medications

Name of Medication	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies and Other Allergies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DNR or other Advanced Directives (valid DNR order and/or state approved bracelet required)

Preferred Hospital Destination \_\_\_\_\_

Miscellaneous Information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_