MAPS EMERGENCY MEDICAL INFORMATION

LAST NAME	**FIRST NAME**		**MIDDLE INITIAL**
STREET ADDRESS	**CITY**	**STATE**	**ZIP**

PURPOSE: The purpose of this form is to provide emergency medical personnel with pertinent medical information about you in case of injury or other medical emergency while you are volunteering at the MAPS Air Museum. This information will remain confidential and will **ONLY** be provided to emergency personnel in the event of a medical emergency while here at the museum.

Date of birth (MM/DD/YYYY)	Blood type:

List hearing difficulties:

List vision difficulties:

Do you wear dentures? (Upper/Lower/Both)	Do you wear contact lenses? (Yes/No)

Are you allergic to any medications or materials (i.e., latex)? (Yes/No) _____
(If **YES**, indicate medication or material.)

Current and past **major** medical conditions:

Current medications (if possible, include dosage and frequency):

Primary care physician:
Name:
Phone #:

Emergency contact information:
Name:
Relationship:
Phone #:

Hospital preference (if practical):
Hospital name:
Location:

Signature:	*Date:

*The information on this form should be updated annually and re-dated with the new date initialed.