



Vacaville Fire Department Medical Emergency Data System

Name _____ Date _____

Address _____ Phone _____

Date of Birth _____ Age _____ Sex _____ Weight _____ Blood Type _____

Physician _____ Hospital of Choice _____

Please list your medical history, such as: diabetes, asthma, hypertension, emphysema, cardiac problems, bleeding problems, cancer, seizures, and other conditions.

Please list medications and their dosages:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies to medications:

Contacts in case of emergency:

Name _____ Phone _____

Name _____ Phone _____

Special Needs:
