SAGAN Life®

Elderly Parent Medical Emergency Form

IDENTIFICATION

Name _____ (FIRST / MIDDLE INITIAL / LAST) DOB ____ ____ _____ (M / D / Y) Male / Female _____

Home Address _____ City _____ State _____ Zip Code _____

Phone Home _____ Work _____ Cell _____ Email _____

Height _____ Weight _____ Eye Color _____ Blood Type / RH Factor _____ Identifying Marks _____

Key Information for Emergency Medical Personnel:

EMERGENCY CONTACTS

Main Contact Name _____ (FIRST / LAST) Relationship _____

Phone Home _____ Work _____ Cell _____ Email _____

Local Contact Name _____ (FIRST / LAST) Relationship _____

Phone Home _____ Work _____ Cell _____ Email _____

Out-Of-Town Contact Name _____ (FIRST / LAST) Relationship _____

Phone Home _____ Work _____ Cell _____ Email _____

Work Contact Employer _____ Address _____ (STREET / CITY / STATE / ZIP)

Phone _____ Supervisor Name _____

Supervisor Work Phone _____ Supervisor Cell _____ Supervisor Email _____

PHYSICIANS

Primary Physician _____ (FIRST / LAST) Specialty _____

Phone _____ Hospital Affiliation _____

Physician _____ (FIRST / LAST) Specialty _____

Phone _____ Hospital Affiliation _____

Physician _____ (FIRST / LAST) Specialty _____

Phone _____ Hospital Affiliation _____

Dentist _____ (FIRST / LAST) Phone _____

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MEDICATIONS

Pharmacy _____ Location _____ Phone _____

STREET CITY STATE ZIP

Pharmacy _____ Location _____ Phone _____

STREET CITY STATE ZIP

Prescription Medication

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

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Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

ALTERNATIVE MEDICATIONS/SUPPLEMENTS

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

ALLERGIES AND CHRONIC CONDITIONS

Allergy Type _____ Severity _____ Frequency/Last Occurance _____

Notes _____

Allergy Type _____ Severity _____ Frequency/Last Occurance _____

Notes _____

Chronic Condition _____ Severity _____ Current Treatment _____

Chronic Condition _____ Severity _____ Current Treatment _____

HEALTH INSURANCE

Health Insurance Company _____ Member Number _____

Policy Number _____ Group Number _____

Hospital Of Choice _____ Agent Name _____ Agent Number _____

WILLS, LIVING TRUSTS & POWER OF ATTORNEY

Will ☐ YES ☐ NO Location _____

Living Trust ☐ YES ☐ NO Location _____

Power Of Attorney/Health Directive ☐ YES ☐ NO Location _____

NOTES

Other Additional Information: