



**EMERGENCY INFORMATION**  
**Informacion de emergencia**

**NAME / IDENTIFIERS** *Nambre/ Identificadaes*

**Last:**  
*Apellido*

**Sex:**  
*Sexo*

**First:**  
*Nambre*

**DOB:** / /  
*Fecha de nacimiento*

**Height:** *Altura*

**Weight:** *Peso*

Your  
Photo  
Here

Si Foto Aqui

**MEDICAL CONDITIONS**  
*Condiciones Medicas*

**Blood Type:**  
*Tipo de Sangre*

**MEDICATIONS** *MEDICA MENTOS*

**ALLERGIES** *ALERGIAS*

Voltear **OVER**



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#### EMERGENCY CONTACT INFORMATION *Contacto caso de emergencia*

**Name:**

*Nambre*

**Phone:**

*Telefono (     )*

**Address:**

*Direccion*

#### PREFERRED MEDICAL TREATMENT *Atencion medica preferida*

**Hospital:**

*Direccion*

**Organ Donor:** ☐ Yes ☐ No

*Donador de organos* ☐ Si ☐ No

**Primary Care Physician:**

*Doctor Personal*

**Phone:**

*Telefono (     )*

#### ADDITIONAL INFORMATION / REQUESTS *Informacion adicional / solicitudes*

#### CONSENT TO TREAT *Consentimiento de atencion medica*

*The below parent/guardian hereby authorizes any medical, surgical or hospital service that may be rendered to the above minor child under the general or special instructions of any physician licensed to practice medicine, whether the treatment be at a hospital or the office of said physician. This request will be effective as of:                      and will expire after:*

**Signature:**

**Date:**     /     /

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