



PELAGIC SAILING CLUB FILE FOR LIFE

EMERGENCY MEDICAL INFORMATION

Date Updated: _____

Name: _____

Address: _____

Sex: Male / Female Date of Birth: _____

Primary Care Doctor: _____

Phone #: _____

Medical Insurance Co. _____

Policy #: _____

Other Medical Insurance: _____

Policy #: _____

Medicare / Medicaid: _____

Policy #: _____

Health Care Power of Attorney Yes / No Need Copy to be enforced

Name / Details: _____

EMERGENCY CONTACTS

Name: _____

Phone -M: _____ Phone-H: _____

Name: _____

Phone -M: _____ Phone-H: _____

Update this form whenever you have a change of medication or medical history.

You can also keep a copy in a sealed envelope on your refrigerator. For additional copies of this form please contact Pelagic Sailing Club

www.pelagicsailingclub.org

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING

Include medications that you are taking routinely and "as needed."

Name of prescription, Over-the-counter medication, vitamins/supplements	Dosage	Frequency

MEDICAL HISTORY

Conditions / Surgeries / Hospitalizations: _____ Date: _____

MEDICINE ALLERGIES

Drug: _____ Reaction (describe): _____

ALLERGIES

NKDA = No Known Drug Allergies

Latex Yes / No Eggs / Dairy Yes / No

Fish Yes / No Peanuts / Nuts Yes / No

Other: _____

Completion of this form is voluntary. Please complete and keep in an envelope. In large, bold print on both sides of the envelope print "Emergency Medical Information for (your name)". Consider placing the envelope in a clear waterproof bag in a safe central location on the boat. Prior to commencing a trip tell the skipper and/or a responsible person of the file and its location. In the event of a medical emergency any information provided will be released to emergency medical responders.

Use additional page(s) as needed.

CSpear1412

**PELAGIC SAILING CLUB
FILE FOR LIFE
EMERGENCY MEDICAL INFORMATION
for**

Fold and insert in zip lock plastic bag

