DETAILED INFORMATION: ADULT

Name: ______________________________________ **DOB:** ___________ M ☐ F ☐
Height: __________ **Weight:** ________ **Hair Color:** __________ **Eye Color:** ________

Employer Name/Address/Phone: ____
____

Wear eyeglasses or contacts: Yes ☐ No ☐

Any medical condition of which emergency provider should be aware (list conditions such as diabetes, high blood pressure, pacemaker, Alzheimer's, etc.):

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Any known allergies? If so, list: ____
Prescription medications currently taking:

____
____
____

Other important information: ____

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