EMERGENCY CONTACTS

Name _____

Relation _____

1-Phone _____

2-Phone _____

3-Phone _____

Address _____

City _____ State _____ Zip _____

Name _____

Relation _____

1-Phone _____

2-Phone _____

3-Phone _____

Address _____

City _____ State _____ Zip _____

Name _____

Relation _____

1-Phone _____

2-Phone _____

3-Phone _____

Address _____

City _____ State _____ Zip _____

IMPORTANT INFO

_____

_____

_____

_____

EMERGENCY INFORMATION SYSTEM

This medical form is designed to supply first responders with critical information about you during in an emergency, when you might not be able to communicate yourself.

Participation is voluntarily and authorizes the disclosure to, and use of, your medical information by first responders for the purpose of offering assistance when involved in an accident.

For more information,

call 801-587-9195, or 801-965-4400 or visit utahyellowdot.com
Downloadable forms are available.

Sponsored and funded by:

HEALTH
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FIRE AND RESCUE
EMERGENCY SERVICES
LAW ENFORCEMENT

THE YELLOW DOT PROGRAM
MEDICAL INFORMATION FORM

PHOTO OF PARTICIPANT

This is important for quick identification.

Name _____

Answers to _____

Primary Language _____

The Yellow Dot Program

This program acts as a facilitator only. All information provided on this form below is your sole responsibility. Please update as needed.

Copy this form or download at utahyellowdot.com.

PARTICIPANT

Name _____

Address _____

City _____

State _____ Zip _____

☐ Male ☐ Female

Date of Birth _____ Blood Type _____

HOSPITAL PREFERENCES

(This will not guarantee transport to any of these locations, the situation may determine other considerations)

1 _____

2 _____

3 _____

MEDICAL INSURANCE?

☐ Medicare ☐ Medicaid ☐ Other

Company name _____

Phone _____

Group number _____

PRIMARY PHYSICIAN INFORMATION

Name _____

Phone _____

Address _____

City _____ State _____ Zip _____

ADDITIONAL PHYSICIAN INFORMATION

Physician _____

Phone _____

Address _____

City _____ State _____ Zip _____

MEDICAL HISTORY

Knowing your history is not only important to the type of care you can receive, but also could explain symptoms that you may be showing.

☐ No known conditions

☐ HIV
☐ Heart Disease
☐ Parkinson's Disease
☐ Pacemaker
☐ Dementia/Alzheimer
☐ Diabetic
☐ Impaired Hearing
☐ Impaired Vision
☐ Blood Clotting Disorder
☐ COPD
☐ Asthma
☐ Seizures
☐ CHF

☐ Cancer of _____

☐ Medication Delivery Port _____

Other _____

_____

_____

_____

_____

SURGERIES

_____

_____

_____

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ALLERGIES

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_____

MEDICATIONS (name and dosage)

☐ NONE

_____

_____

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