EMERGENCY INFORMATION FORM

Update when your information changes. Review the form at least every six months when you change the time on your clocks. If you need a new form, scan the code to the left with your smart phone or visit www.wcsoga.com and fill out a form.

Use of this form is voluntary. By using this form, you understand that first responders and medical personnel will use this information as they see fit.

Personal Information (Please Print Legibly)

Last Name: _____ First Name: _____ MI: _____

❑ Female Height: _____ Weight: _____

❑ Male Eye Color: _____ Hair Color: _____

Address: _____

Emergency Contact 1: _____ Relationship: _____

Phone Number: _____

Emergency Contact 2: _____ Relationship: _____

Phone Number: _____

Primary Doctor: _____ Phone Number: _____

❑ Organ Donor Pharmacy: _____

Medical History (check all boxes that apply to you. Please Print Legibly)

Heart Conditions	Sensory Impairments	Auto-Immune Conditions
☐ Heart Rhythm/AFIB/ Abnormal Heart Rate	☐ Visually Impaired/ Blind ☐ Hearing Impaired/ Deaf	☐ Hepatitis
☐ Angina/Chest Pains	**Other Medical Conditions:**	☐ Lupus
☐ Defibrillator/Pacemaker	☐ Bleeding/ Clotting Disorder	☐ HIV/Aids
☐ Heart Attack Date of Last __/__/____	☐ Cancer (Type: _____)	☐ Myasthenia Gravis
☐ Heart Failure/CHF	☐ Currently Pregnant Due Date: __/__/__	**Lung Conditions**
☐ Heart Valve Replacement	☐ Diabetes	☐ Asthma
☐ High Blood Pressure	☐ Dialysis/ Kidney	☐ COPD/Emphysema
Brain/Nervous System Conditions	☐ Sickle Cell Disease	**Allergies: Indicate all allergies and reactions**
☐ Anxiety	☐ Tuberculosis	☐ No Known Allergies
☐ Dementia/Alzheimer's	☐ Last Tetanus Shot Date: __/__/__	☐ Latex-
☐ Depression	☐ Other:	☐ X-Ray Dyes-
☐ Multiple Sclerosis	**Health Habits**	☐ Foods-
☐ Parkinson's Disease	Tobacco Use: Type: _____	☐ Insect Stings-
☐ Schizophrenia	Alcohol Use: ___ times per_____	☐ Medications-
☐ Seizure Disorder	Illicit Drug Use: _____	☐ Other:
☐ Stroke/TIA		☐
☐ Major Surgeries:		

Other important Information:_____

_____

Emergency Contact Information:

Name: _____

Relationship: _____

Address: _____

Telephone Number: _____Cell Number:_____

Name: _____

Relationship: _____

Address: _____

Telephone Number: _____Cell Number:_____

Name: _____

Relationship: _____

Address: _____

Telephone Number: _____Cell Number:_____

Responsible Party Completing This Form:

Name: _____

Relationship: _____

Address: _____

Telephone Number: _____Cell Number:_____

Signature: _____ Date: _____

Vehicle Information:

Make: _____ Model: _____

Tag Number: _____VIN: _____

Any decals or marks on vehicle: _____

_____

****Please submit a picture of person along with the form.****

Please email this form to the 911 Director at amy.roberson@waynecounty-ga.gov.
Form can also be mailed to or dropped off at 155 N. Wayne Street, Jesup, GA, 31546.