**Alameda County Emergency Medical Services Agency**

A Division of the Public Health Department

1000 San Leandro Blvd

San Leandro, CA 94577

(510) 618-2050

website: acgov.org/ems

e-mail: alcoems@acgov.org

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**Instructions:**

Take the Emergency Information Card to your physician visits and update when changes occur or at least once a year.

Copy updated information on to this card – use pencil.

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### Current Medications

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<th>Dosage</th>
<th>Frequency</th>
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**Pharmacy:** ____________________________  **Phone:** ____________________________

**Primary Language:** ____________________________________________________________

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**EMERGENCY INFORMATION CARD**
EMERGENCY MEDICAL INFORMATION CARD

Date of form updated: Month: __________ Year: __________
Name: ___________________________ Phone: ___________________________
Address: ___________________________ Phone: ___________________________
Date of Birth: ___________________________ Blood Type: ___________________________
Parent/Legal Guardian: ___________________________
Do Not Resuscitate Form is attached, or located at: ___________________________

EMERGENCY CONTACTS

Name: ___________________________ Home Phone: ___________________________
Cell Phone: ___________________________ Work Phone: ___________________________
Address: ___________________________

Name: ___________________________ Home Phone: ___________________________
Cell Phone: ___________________________ Work Phone: ___________________________
Address: ___________________________

MEDICAL CONDITIONS

1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________
4. ___________________________________________________________
Allergies: _______________________________________________________

PHYSICIAN INFORMATION

Primary Physician: ___________________________
Phone: ___________________________ Fax: ___________________________
Specialty Physician: ___________________________
Phone: ___________________________ Fax: ___________________________
Hospital Preference: ___________________________