Personal Information Form

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CMC'er: Complete Card and Place in Your First-Aid Kit

Name _____ Date ___/___/___

DOB ___/___/___ Gender _____ Blood Type _____

Weight _____ Age _____

Home Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

E-mail _____

PERSON TO NOTIFY Name _____

Relationship _____ Phone _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

E-mail _____

RELEVANT MEDICAL HISTORY (injuries, illnesses) _____

_____

Implants or medical devices _____

Medic alert tag: Y N (specify) _____

Allergies _____

Medicines currently used _____

Primary care doctor _____ Phone: _____

Notes

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