



**Badge #** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Lubbock EMS**  
**Personnel Medical Information**  
**As of this date:** \_\_\_\_\_

**Please be as complete as possible.**

**DOB:** \_\_\_\_\_ **S.S.#:** \_\_\_\_\_

**Ht:** \_\_\_\_\_ **Wt:** \_\_\_\_\_ **Race:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Pager:** \_\_\_\_\_

**Religious Preference:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Pager:** \_\_\_\_\_

**Insurance Carrier:** \_\_\_\_\_

**Physician:** \_\_\_\_\_

**Hospital:** \_\_\_\_\_

**Medical Information:**

**History:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medication(s):** \_\_\_\_\_

**Blood Type:** \_\_\_\_\_ **Donor:** Yes No **DNR:** Y N

**Signature:** \_\_\_\_\_