U.S. COAST GUARD AUXILIARY MEDICAL INFORMATION/NOTIFICATION THIS INFORMATION IN THE SEALED ENVELOPE

WILL BE GIVEN ONLY TO THE EMT OR DOCTOR IN THE EVENT OF A SERIOUS MISHAP

Name: Date Completed:

Male Female Age:

Blood Type:

Address:

City: State: Zip:

Phone #s: Home: - -

Work: - -

Auxiliary Member Number: Doctor(s) Name and Phone Number:

(Division

Flotilla )

# - -

# - -

Insurance Name: Medicare Number:

Medi-Cal Number:

Medicare Part A: Medicare Part B:

Medical Plan: Plan #: Phone: \_ \_ \_ - \_ \_ \_ - \_ \_ \_ \_

Hospital Preference:

Allergies:

**HEALTH HISTORY**

1. 2.

Medications: Dosage: Medications: Dosage:

1. 3.

2. 4. I have:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Epilepsy  Heart Prob |  | | Yes | No |
|  |  |
| lems |  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies: Asthma: Diabetes: |  | Yes | No |
|  |  |
|  |  |  |
| Insulin Dose: |  |  |

I wear:

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Lenses: Glasses: |  | Yes | No |
|  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Hearing Aids: Dentures: |  | Yes | No |
|  |  |
|  |  |  |

Other information about my health not covered above:

Member Signature: Date:

**EMERGENCY NUMBERS IN ORDER OF PREFERENCE:**

Name: Phone Number:

- -

Relationship: Address:

Name: Phone Number:

- -

Relationship: Address:

Name: Phone Number:

- -

Relationship: Address:

Minister or Rabbi's Name and Phone Number:

Name: Phone Number:

- -

Durable Power of Attorney Signed: Yes No

Name of person(s) holding Durable Power of Attorney:

Name: Phone Number:

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