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: __ __ __ __ __ __ __ (Division __ __ Flotilla __ __)

Doctor(s) Name and Phone Number:

_____ # __ __ __ - __ __ __ - __ __ __ __

_____ # __ __ __ - __ __ __ - __ __ __ __

Insurance Name: _____

Medicare Part A: ____

Medicare Number: _____

Medicare Part B: ____

Medi-Cal Number: _____

Medical Plan: _____ Plan #: _____ Phone: _ _ _ - _ _ _ - _ _ _ _

Hospital Preference: _____

HEALTH HISTORY

Allergies:
1. _____ 2. _____

Medications:	Dosage:	Medications:	Dosage:
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

I have:

	Yes	No		Yes	No
Allergies: _____			Epilepsy _____		
Asthma: _____			Heart Problems _____		
Diabetes: Insulin Dose: _____					

I wear:

	Yes	No		Yes	No
Hearing Aids: _____			Contact Lenses: _____		
Dentures:			Glasses:		

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: __ __ __ - __ __ __ - __ __ __ __