

LUCAS OIL PRODUCTS, INC.
EMERGENCY MEDICAL INFORMATION FORM

**THIS DOCUMENT WILL REMAIN CONFIDENTIAL AND WILL ONLY BE SUBMITTED TO EMS IN
THE EVENT OF AN EMERGENCY.**

First Name _____ Last Name _____

Address _____ City _____ St. _____ Zip _____

Home Phone _____ Business Phone _____ Birth Date _____

Emergency Contact Name _____ Phone _____ Relationship _____

Age _____ Wt: _____

Medications presently using: (Prescribed /OTC meds) _____

Medical Allergies _____

Past Medical History: (explain) _____

High Blood Pressure: yes/no Diabetes: yes/no Heart Disease: yes/no Asthma: yes/no
Other: _____

Blood Type _____ Contact Lenses _____

Do you have hospitalization insurance? YES _____ NO _____ (If the answer is yes, please complete the following)

COMPANY: _____

GROUP # _____

POLICY# _____

CONTACT PHONE _____

PARTICIPANTS SIGNATURE _____ DATE _____