



Springfield First Aid Squad

Facts for Life

Name: _____

Age: _____ Birth Date: _____

Address: _____ City: _____ State: _____

Home Phone: (____) _____ Gender: Male Female

Primary Doctor: _____ Phone: (____) _____

Secondary Doctor: _____ Phone: (____) _____

Emergency Contact: _____ Phone: (____) _____

Emergency Contact: _____ Phone: (____) _____

DNR: Yes No Location: _____

Living Will: Yes No Location: _____

Hospital Preference: _____ Blood Type: _____ Weight: _____

Present Medications	Allergies (Medication & Foods)	Medical Conditions

Please fill out this form and place it on your refrigerator. Date this form was completed: _____