

OHIO DISASTER RELIEF OPERATIONAL PROCEDURES MANUAL
OHIO DISASTER RELIEF
EMERGENCY MEDICAL INFORMATION

Volunteers are requested to provide the following information to the unit director upon arrival at the disaster work location.

Today's date: _____

Name: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthday: _____ Marital Status: _____

Spouse Name: _____ Work Phone: _____

Other Person to contact in an Emergency:

Name: _____ Relationship to you: _____

Home Phone: _____ Work Phone: _____

Member of _____ Church

Medical Problems: _____

Physical Handicaps: _____

Restrictions: (such as lifting, driving, standing, etc.) _____

Allergies: Food: _____

Symptoms or Reactions: _____

Antidote: _____

Allergies: Other: _____

Symptoms or Reactions: _____

Antidote: _____

Medication: Name of medication: _____

Dosage: _____ Frequency: _____

Side effects: _____

Name of medication: _____

Dosage: _____ Frequency: _____

Side effects: _____

Health Insurance Co. _____

Policy or Group No. _____

Social Security Number _____

Date of last tetanus shot _____