

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
Allergies: _____		
Asthma: _____		
Diabetes: Insulin Dose: _____		

	Yes	No
Epilepsy _____		
Heart Problems _____		

I wear:

	Yes	No
Hearing Aids: _____		
Dentures: _____		

	Yes	No
Contact Lenses: _____		
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: _____
_____ - _____ - _____