Fill out the form, print 2 copies, double sided and cut along the outer dotted line. One copy will be provided to your road captain and the other keep on your person.

INSURANCE INFORMATION

COMPANY POLICY # PHONE

MEDICARE #

PHYSICIANS PHONE

DR. ( )

DR. ( )

DR. ( )

PLEASE CONTACT THE PERSON(S) OR ORGANIZATION(S) LISTED BELOW FOR INFORMATION ON LIVING WILL OR DONOR INFORMATION

NAME

PHONE ( )

NAME

PHONE ( )

PHARMACIST

PHARMACY LOCATION

PHONE ( ) FAX ( )

BLOOD TYPE HEIGHT WEIGHT

DATE OF YOUR LAST TETANUS SHOT / /

DATE OF YOUR LAST PNEUMONIA SHOT / /

DATE OF YOUR LAST FLU SHOT / /

STOCK #: 30-082 ARTWORK #: 41MEM0711

NAME

ADDRESS

CITY STATE ZIP

PHONE ( )

DATE OF BIRTH ☐ MALE ☐ FEMALE

RELIGION

DATE THIS MEDICAL FORM WAS COMPLETED / /

EMERGENCY MEDICAL RECORD

AMERICAN LEGION RIDERS

(XXX) XXX-XXXX

website info

ATTENTION POLICE & MEDICAL PERSONNEL

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME

ADDRESS

CITY STATE ZIP

PHONE ( )

LIVING WILL? ☐ YES ☐ NO DONOR? ☐ YES ☐ NO

DURABLE POWER OF ATTORNEY FOR HEALTH CARE? ☐ YES ☐ NO

I AM TAKING THE FOLLOWING MEDICATIONS INCLUDING OVER THE COUNTER AND HERBAL PRODUCTS

DRUG NAME	STRENGTH	DOSAGE	HOW OFTEN/WHEN	WHAT IT IS FOR

HAVE THIS VERIFIED BY YOUR PHYSICIAN OR PHARMACIST EACH VISIT. **KEEP THIS CARD WITH YOU AT ALL TIMES.**

MEDICAL CONDITIONS (DIABETES, ETC.)	**ALLERGIES** (PENICILLIN, SULFA, ETC.)	REACTION TO ALLERGIES