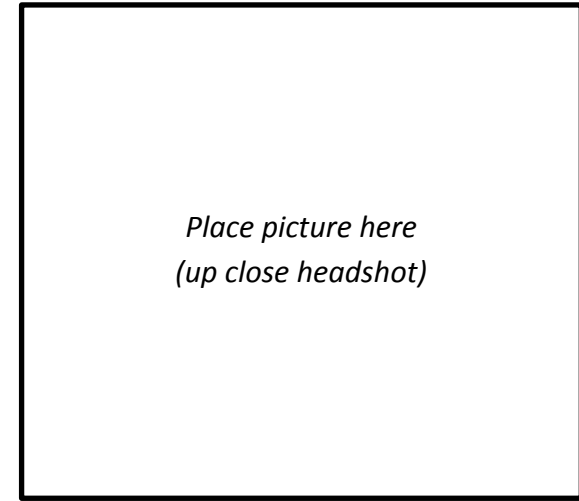


# Washington State Yellow Dot Program



Please Note: The Yellow Dot Program is for informational purposes only. All information contained herein is supplied by, and is the sole responsibility of, the participating person listed.

# Emergency Medical Information



Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Gender  Male  Female  Non-binary

Other \_\_\_\_\_

Blood Type \_\_\_\_\_

Allergies \_\_\_\_\_

\_\_\_\_\_

Diabetic?

Insulin Dependent?

Pacemaker?

Other? \_\_\_\_\_

Please complete **IN PENCIL** to facilitate updates as information changes. Include Area Codes with all phone numbers.

**Date** *(update this any time information changes)* \_\_\_\_\_

### Medical Conditions

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### Medications/Doses *(Generic name if known and date prescribed)*

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### Medical Insurance

Provider \_\_\_\_\_

Group# \_\_\_\_\_

ID# \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

### Family Physician

Name \_\_\_\_\_

City/State \_\_\_\_\_

Office Phone \_\_\_\_\_

### Other Information

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