

M.I.S.F.I.T.S.

EMERGENCY INFORMATION

THE INFORMATION CONTAINED IN THIS RECORD IS FOR THE USE OF EMERGENCY PERSONNEL ONLY.

The information contained here, and any documentation accompanying it may contain confidential information intended solely for the use of the individual or entity named below. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, disclosure, or copying of this communication, or the taking of any action in reliance on the contents of this information is strictly prohibited by law.

Participant's Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Telephone :(_____) _____ - _____ **Cell Phone:** (_____) _____ - _____

Work Telephone :(_____) _____ - _____ **Extension:** _____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone Number: (_____) _____ - _____

Second Emergency Contact Information:

Name: _____

Relationship: _____

Second Emergency Contact Phone Number (_____) _____ - _____

Personal Medical Information:

Name: _____

Sex; _____ Organ Donor? _____

Date of Birth: ____ / ____ / ____ Blood Type: _____

Social Security Number: _____ - _____ - _____

List all Known Allergies:

List any Medications Currently being Used including Eye Drops:

List all Known Medical Conditions Past and Present:

How Often Do You Use Alcohol? Never Seldom Occasionally Frequently Daily

How Often Do You Smoke? Never Seldom Occasionally Frequently Daily

Do you use Illegal Drugs or Narcotics? If so, list them here: _____

PARTICIPANT'S MEDICAL HISTORY

NAME: _____ AGE: _____

DATE OF BIRTH: _____ SEX: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

OCCUPATION: _____

YOUR PERSONAL PHYSICIAN: _____

ADDRESS: _____

A. Have you been treated for, have you ever had, or have you now any of the following? (For each "yes" checked, describe or explain below or on a separate sheet.)

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Frequent or severe headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Dizziness or fainting spells |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Unconsciousness for any reason |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Eye trouble, except glasses |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Allergy to medications or other drugs other than hay fever and asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Diabetes – insulin, and how much |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Heart trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. High or low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Anemia or other blood diseases, including abnormal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Stomach trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Kidney stone or blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Sugar or albumin in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Epilepsy or fits |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Nervous trouble of any sort |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Any mental trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Any drug or narcotic habit |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Excessive drinking habit |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Attempted suicide |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. Motion sickness requiring drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. Admission to hospital within the last 12 months – List date: |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. Operations involving eyes, brain, heart, nerves or blood vessels |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. Amputation or physical disability |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. Other illnesses |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. Immunization against tetanus (by toxoid) – List date: |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. Tetanus boosters – List dates: |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. Rejection for life insurance |
| <input type="checkbox"/> | <input type="checkbox"/> | 29. Military medical discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | 30. Loss of Color Vision |

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INSTRUCTIONS FOR EMERGENCY INFORMATION BINDER

The EMERGENCY INFORMATION BINDER has been put together so that we may provide vital information in the event of an emergency.

We have no way of telling what information could be valuable for this purpose until an incident occurs. Therefore, it is in your best interest to provide as much information as you can.

This information is PERSONAL & CONFIDENTIAL. After you have completed filling out the paper work, place it into the supplied envelope and seal the envelope. You are the only one who knows what information is in that envelope.

The envelope will remain sealed until such a time that we feel it is in your best interest for us to turn it over to Emergency Personnel.

This is YOUR property that will be kept in the possession of the Maryland Illegal Soapbox Federation & Incline Trials Society (MISFITS). You can request that it be returned to you at any time for any reason.

While MISFITS will make every reasonable attempt to protect this information, you agree to hold them harmless should any type of damages occur from the dissemination of the enclosed information.

In addition to the information on the sheets enclosed, you may want to provide additional information that has not been requested. Feel free to do so. Again, the information contained in your envelope is there for your best interest.

You may also wish to include a photo copy of your driver's license, as this is the document most Emergency Personnel are familiar working with.

After you have enclosed the information you want in the envelope, seal the envelope.

On the outside of the envelope, legibly write your name as well as your "driver" name if you use one. In this way we will be able to quickly determine which envelope contains your information should you be unable to tell us.