Fill out the form, print ***two*** copies, double sided and cut along the outer dotted line. One copy will be provided to your road captain and you will be given a plastic sleeve for the other.

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

(317) 630-1265

www.legion.org/riders

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**