City of Duluth
EMERGENCY MEDICAL INFORMATION

Employee Name: _____ Date: _____

Completion of the remainder of this form is voluntary. Any medical information disclosed is treated as Protected Health Information (PHI) and remains confidential. We will only share this information with treating medical personnel, under court order, or as otherwise permitted by federal or state law.

(1) List any medications, food, animals, etc. you are allergic to:

_____

_____

(2) List any diseases or medical conditions that treating medical personnel might need to know about, if you are unable to tell them:

_____

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(3) Is there anything else you wish to share with us that might be of benefit to you in an emergency?

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Rev. 5/8/2013