Maritime Medical Access Medical Information Sheet

Patient Name: _____ **Date of Incident (M/D/Y):** ____/____/____

DOB (M/D/Y): ____/____/____ **Age:** _____ **Sex:** _____ **Vessel Name:** _____

Patient Address: _____

Patient Phone: _____ **Patient Email:** _____

CURRENT MEDICAL CONDITIONS:

_____

_____

_____

_____

ALLERGIES:

_____

_____

_____

PAST MEDICAL/SURGICAL HISTORY:

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS:

_____

_____

_____

_____

_____

_____

ADDITIONAL NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

RECENT HOSPITALIZATIONS:

_____

_____

_____

_____

_____

The above-named individual hereby authorizes the release of medical records to all relevant healthcare facilities involved in their continued care and to any emergency contact(s) listed below:

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____