

Comanche Nation Fire Department Emergency Health Information



NAME:	
PHYSICAL ADDRESS:	
CITY/ STATE/ ZIP	PHONE
DOB:	ALLERGIES:
ADVANCED DIRECTIVE/ DNR?	
EMERGENCY CONTACT:	

Disclosure of Information

I, Name: _____, hereby authorize the sharing of my health information with the Comanche Nation Fire Department. This information may be utilized for emergency situations and healthcare operations as outlined in this document. *All information provided is strictly confidential and will not be disclosed to any third party.*

Signature:	Date:
Preferred Medical Provider:	
Medical Diagnosis:	

Comanche Nation Fire Department Emergency Health Information



The information you submit to the Comanche Nation Fire Department will be utilized to enhance our maps for various potential situations. We respectfully request that you provide a list of any prescribed medical devices you utilize, including but not limited to oxygen tanks, nebulizers, and any daily medications prescribed by your physician. *Please be advised that the provision of this information is entirely voluntary.*

Assistive devices such as oxygen, breathing Tx, home dialysis wheelchair, walker, cane:

Surgical Procedures:

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Current Medications

Additional Household Members
