

**Emergency Information Form
2024-2025 Session of the Grand Chapter of Ohio
Order of the Eastern Star**

(Please note, this information is confidential and is only to be used for your safety and protection)

Last Name: _____ First Name: _____

Complete Address: _____

Chapter Name and Number: _____ State: _____

Please Provide the Following information:

Name of Place Staying: _____ Phone: _____

Is there anyone with you that knows your medical conditions and could accompany you for emergency services?

Who? _____ Where are they staying? _____

List any health conditions (ie., Heart Condition, Diabetes, Physical Handicap, ect.)

Are you allergic to any medications? If so, please indicate here:

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____ PHONE: _____

RELATIONSHIP TO YOU: _____ CELL PHONE: _____

IN THE EVENT THIS PERSON IS NOT AVAILABLE, WHO ELSE CAN BE CONTACTED?

NAME: _____ PHONE: _____

Relationship to you: _____ Cell Phone: _____

The local Certified Emergency Medical Personnel will be called for all emergencies. The above information will be made available to them and to the Hospital involved, should that be necessary.

It is private information, subject to the Federal Health Privacy Policies and will be honored as such.