SENECA COUNTY
Emergency Medical Services

This is an administrative form only for gathering demographic information. Please shred when complete

Name______________________________ Date of Birth:_____________________________ Age:________

Address____________________________________City______________________State_____Zip___________

SSN:___________________________________Race_____________________________

Chief
Complaint:____

Medical
History____

____

Current
Medications:____

____

Allergies:____

Vital Signs:
Heart Rate:________ B/P_____/______ Respirations:__________________ sPO2______ Glu________

Notes:

** This sheet is not a part of the medical record, please shred after the above information is entered into emscharts**

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