



**Capital Area Public Health Network
First Responder/Household Member Information Form****

Last Name _____
 First Name _____ MI _____
 Address _____
 City _____ State _____ Zip _____
 Phone: Home _____ Work _____ Cell _____
 E-mail _____

List names of first responder and all household members	Date of Birth	*Allergic to any medicine(s) - list name of medicine(s)	*Allergic to any medicine(s) - list name of medicine(s)	*Allergic to any medicine(s) - list name of medicine(s)
TOTALS				

Signature:	Date:
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***If you are unsure of your response listing a medical allergy, please consult with your physician. List only severe or life threatening allergic reactions to medication(s)**
**** To be completed by each first responder in advance and retained by the agency.**