

**EMERGENCY HEALTH INFORMATION  
CARD APPLICATION**

For electronic application, please e-mail this signed application and photo ID to [information@guamlsc.org](mailto:information@guamlsc.org).

**Please print clearly**

FULL NAME (Last, First, Middle)		DATE OF BIRTH (Month / Day / Year)	
PHYSICAL ADDRESS: (House/Apt No., Street, City)		State	Zip Code
MAILING ADDRESS: (Box No., Street, City)		State	Zip Code

**In case of emergency, please list the name(s) of the individual(s) you would like to be notified:**

CONTACT 1	LAST NAME		RELATIONSHIP	CONTACT NUMBER(S)
	FIRST NAME	MIDDLE INITIAL		
CONTACT 2	LAST NAME		RELATIONSHIP	CONTACT NUMBER(S)
	FIRST NAME	MIDDLE INITIAL		
CONTACT 3	LAST NAME		RELATIONSHIP	CONTACT NUMBER(S)
	FIRST NAME	MIDDLE INITIAL		

**Please provide the following information: (Use the back of this form for additional information)**

CONDITIONS/DISABILITY: \_\_\_\_\_

MEDICATION(S):

1.	2.
3.	4.

ALLERGIES: \_\_\_\_\_

<p>This application is made for the emergency health card which will be made available without charge and is made voluntarily by the applicant. No information provided on this application will be maintained.</p> <p>I understand that with Guam Legal Services Corporation – Disability Law Center (GLSC-DLC) providing me this card, it does not make me a client of GLSC-DLC nor does it create any form of confidential relationship between myself and GLSC-DLC.</p>
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Where would you like your Emergency Health Card delivered to? *Please check one.*

- I will pick it up at GLSC-DLC, 434 W O'Brien Dr Ste 102, Hagatna from Monday-Friday between 8:00am-5:00pm.
- Please send to my mailing address.

PRINT NAME

SIGNATURE

DATE

ADDITIONAL INFORMATION:

\_\_\_\_\_

CONDITIONS/DISABILITY:


\_\_\_\_\_

MEDICATIONS:


ALLERGIES:

\_\_\_\_\_

Card design example.

<b>EMERGENCY HEALTH INFORMATION</b>	
 <p><b>MARIA CRUZ</b>  <b>DOB:</b> 01/01/1966          123 Lada Road          Chalan Pago, Guam          96910</p> <p>In case of an emergency, contact:          Jane Cruz, Sister: 555-1234          Bob Cruz, Brother: 555-0000          Juan Taitano, Social Worker: 555-0001</p> <p><b>If I appear to have problems or other difficulties due to my disability, contact the people on this card.</b></p>	<p><b>Conditions/Disability:</b>          Autism, Bi Polar Disorder, Major Depressive Disorder, Asthma and Diabetes</p> <p><b>Medication:</b>          Zoloft, Prozac, Lithium (or other mood stabilizers), Albuterol (or other asthma medications), and Metformin</p> <p><b>Allergies:</b>          Penicillin, Latex, Gluten, Asprin</p> <p><small>This card was produced by Guam Legal Services Corporation - Disability Law Center (GLSC-DLC) "The Protection and Advocacy System for Guam" through Grant Numbers: 6X985M085-949-01, 2201GUPADD and H240A220061 for the purposes of emergency assistance only.</small></p>

FRONT

BACK

**PHOTO REQUIREMENTS**

- Color photo
- Clear image of face. Up to shoulders.
- Have someone else take your photo. No selfies.
- Use plain background
- JPG file format
- Scanned file of existing photo is acceptable.  
 2x2 inches (51 x 51mm). \*Scanned. Not pictured\*