MEDICAL EMERGENCY INFORMATION

Please place this card on the outside of your refrigerator.
It is your responsibility to keep the information on this card current.

Date Completed

Information

Name _____

DOB _____ M ☐ F ☐

Address _____

City _____ State ____ Zip_____

Phone_____

MEDICATION	DOSAGE	FREQUENCY

Advanced Directives

☐ **DNR – *Do Not Resuscitate***

Location_____

☐ **POLST – *Physician Orders for Life-Sustaining Treatment***

Location _____

Medical Conditions/Surgeries

☐ No known medical conditions

☐ Angina ☐ Asthma ☐ Blood Thinners

☐ Cancer ☐ Congestive Heart Failure (CHF)

☐ Chronic Obstructive Pulmonary Disease (COPD)

☐ Dementia / Alzheimer's ☐ Diabetes

☐ Hearing Impaired ☐ Hemodialysis

☐ Hypertension ☐ Hypoglycemia

☐ Implanted Defibrillator ☐ Pacemaker

☐ Seizure Disorder ☐ Stroke

☐ Other:

_____

_____

_____

Allergies **(List any severe allergies)**

☐ No know allergies

☐ Aspirin ☐ Codeine ☐ Latex

☐ Morphine ☐ Penicillin ☐Sulfa

☐ X-Ray dyes

Other:

_____

_____

Emergency Contact

1. Name _____ Phone_____

Secondary Phone _____ Relationship_____

2. Name _____ Primary Phone_____

Secondary Phone _____ Relationship_____

Physician(s)

1. Name_____

Phone_____

2. Name_____

Phone_____

Glasses/Hearing Aids/Dentures

Do you wear glasses? ☐ Yes ☐ No

Do you wear hearing aids? ☐ Yes ☐ No

Do you wear dentures? ☐ Yes ☐ No

FireMed

Do you have FireMed? ☐ Yes ☐ No

Notes:

_____

_____

_____

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