Emergency Contact 1. Name _____ Phone Secondary Phone ______ Relationship____ 2. Name ______ Primary Phone _____ Secondary Phone _____ Relationship_____ **Glasses/Hearing Aids/Dentures** Physician(s) Do you wear glasses? ☐ Yes ☐ No 1. Name_____ Do you wear hearing aids? ☐ Yes ☐ No Phone _____ Do you wear dentures? ☐ Yes ☐ No 2. Name_____ **FireMed** Do you have FireMed? ☐ Yes □ No Notes:

MEDICAL EMERGENCY INFORMATION





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	1
	1

Information	Advanced Directives
Name	DNR – Do Not Resuscitate
DOB M _ F _	Location
Address	POLST — Physician Orders for Life-Sustaining Treatment
City State Zip	Location
Phone	
	Medical Conditions/Surgeries
MEDICATION DOSAGE FREQUENCY	□ No known medical conditions □ Angina □ Asthma □ Bleeding Disorder □ 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
	│
	-
	☐ X-Ray dyes
	Other: