EMERGENCY MEDICAL INFORMATION

Name ______________________________ Date of Birth ___/___/___

Address ______________________________

Home Phone ______________ Mobile Number ______________

Sex __________ Religion __________ Blood Type __________

Height __________ Weight __________

DNR Yes / No Living Will Yes / No

Paperwork Location ______________

Power of Attorney (Health Care) Yes / No

Name of POA ______________

Phone ______________

Medical History

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Diabetes (Type 1 / Type 2)
- ☐ Thyroid
- ☐ Lung Disease
- ☐ Stomach / GI Issues
- ☐ Liver Disease
- ☐ Cancer__________
- ☐ Renal Disease
- ☐ Stroke
- ☐ Seizure
- ☐ Pacemaker / Defibrillator
- ☐ Neurological Issues
- ☐ HIV
- ☐ Hepatitis
- ☐ Mental Health Issues

Additional Info: ______________

____

____

____

Medication List

Medication	Date (Prescribed)	Dosage

Where are your Medications Located?

____

Medical Allergies

____

____

____

____

Primary Doctor **Phone**

____

Preferred Hospital

____

Surgeries / Major Medical Procedures

____

____

____

EMERGENCY CONTACTS

Name ______________

Phone __________ Relationship __________

Name ______________

Phone __________ Relationship __________

EMERGENCY
CALL 911

EMERGENCY MEDICAL INFORMATION

An **Akron Fire Department** Publication

Print clearly using pencil

Keep medical history & medication list **updated**

Use included magnet

PLEASE HANG ON REFRIGERATOR

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Print clearly using pencil

Keep medical history & medication list **updated**

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EMERGENCY CALL 911

ATTENTION

PARAMEDICS