

EMERGENCY CHECKLIST

Name: **Date of Birth:**
Address:
Religion: Male Female

Emergency Contacts

Name:
Address:
Relation:
Home Phone: Work Phone:
Cell Phone:

Name:
Address:
Relation:
Home Phone: Work Phone:
Cell Phone:

Name:
Address:
Relation:
Home Phone: Work Phone:
Cell Phone:

Medical Data

Last Updated:
Doctor Name:
Doctor Name:
Blood Type:
Phone: Phone:

Do you have a living will? Yes No
Located:
Do you have a healthcare proxy? Yes No
Located:
Do you have an EMS-NO CPR Directive or DNR Form? Yes No
Located:

Who is authorized to have access to your protected medical information?

.....
HIPPA release located:

MEDICAL PROBLEM	MEDICATION	DOSAGE	FREQUENCY

Medical Condition Checklist

- | | |
|------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> No known medical conditions | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Hemolytic Anemia |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hepatitis—Type |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Implantable Devices: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Laryngectomy |
| <input type="checkbox"/> Cardiac Dysrhythmia | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Memory Impaired |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Valve Prosthesis | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Other: | |
| | |
| | |
| | |

Allergies

- | | |
|-----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> No known allergies | <input type="checkbox"/> Lidocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Novocain |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Latex | <input type="checkbox"/> X-Rays Dyes |
| <input type="checkbox"/> Environmental: | |

Notes