Emergency Medical Information Form

Update this form whenever your information changes.
Review forms for accuracy every six months when you change your clocks during Daylight Saving Time.

Personal Information

Please print clearly.

Last Name:	First Name:	MI:	
DOB:	Height:	Weight:	
Primary Language:			
Physical description: (such as eye color, hair color)			
Address:	City:	State:	Zip:
Emergency Contact 1:	Phone:	Relationship:	
Emergency Contact 2:	Phone:	Relationship:	

- ❑ Advanced Directive, Do Not Resuscitate (DNR/ Clinician Orders for Life-Sustaining Treatment (COLST) (include copy in the envelope)
- ❑ Organ Donor

Medications

Indicate all prescriptions and over the counter medications, supplements, etc. Update this list whenever medications change. If needed, add additional pages or make a copy of your medication list from PCP and enclose in packet.
Please print clearly *Example: Aspirin 60MG Once Daily*

Date Updated
____/____/_____

Medication	Dose	Medication	Dose

More medical history and information on other side

V082024

Medical History

Check all boxes that apply to you. Please print clearly. Update this form regularly.

Medical Conditions
Indicate all past and present health conditions

Heart Conditions

- ☐ Abnormal Heart Rate/ Heart Rhythm/ Afib
- ☐ Angina/Chest Pain
- ☐ Defibrillator/Pacemaker
- ☐ Heart Attack

  Date of Last ____/____/_____
- ☐ High Blood Pressure
- ☐ Heart Failure/CHF
- ☐ Heart Valve Replacement
- ☐ Other:_____

Brain/Nervous System conditions

- ☐ Anxiety
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Lung Conditions
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Stroke/TIA
- ☐ Other:_____

Sensory Impairments

- ☐ Autism Spectrum Disorder
- ☐ Hearing Impairment
- ☐ Visually Impaired/Blind
- ☐ Sensory Processing Disorder
- ☐ Other:_____

Other Medical Conditions

- ☐ Bleeding/Clotting Disorder
- ☐ Cancer: Type:_____
- ☐ Currently Pregnant
  Due Date:_____/_____/_____
- ☐ Diabetes
- ☐ Dialysis/Kidney
- ☐ Sickle Cell Disease
- ☐ Tuberculosis
- ☐ Other_____

Auto-Immune Conditions

- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Myasthenia Gravis
- ☐ Other:_____

_____

Allergies
Indicate all allergies and reactions (swelling of face or tongue, wheezing/trouble breathing, etc.)

- ☐ No Known Allergies
- ☐ Latex
  Reaction:_____
- ☐ Foods
  Types:_____
  Reaction:_____
- ☐ Insect Stings
  Types:_____
  Reactions:_____

Medication Allergies

- ☐ Aspirin
  Reaction:_____
- ☐ Penicillin
  Reaction:_____
- ☐ Morphine
  Reaction:_____
- ☐ Other Medications
  Type and Reaction:_____
  _____

Other Allergies

- ☐ Type and Reaction:_____
  _____

Major Surgeries(Types and Dates):

Other important medical information

(Example: Assistive Devices, special healthcare needs, behavior supports such as fears, ways to calm down in an emergency, procedure NOT to perform)

More medical history and information on other side.

To order more Yellow Dot Kits or Emergency Information Forms, scan the QR code with your phone camera.