PERSONAL PLANNING FOR EMERGENCIES
Keep information up to date!

Last reviewed on: _______MO _________YR

Use pencil to fill out one card for each person.
Fold card; insert in red magnetic pouch or Ziplock bag.
Place on refrigerator door. Update as changes occur.
Call with questions.

Name: ___________________________________
Address: _________________________________
Date of Birth: ________________________ Gender: M F
Primary Language: _____________________ Religion___________
Primary Doctor's Name: __________________________
Doctor's Phone Number: _________________________

CHECK ALL MEDICAL CONDITIONS THAT EXIST

☐ No known medical conditions
☐ Abnormal EKG
☐ Adrenal Insufficiency
☐ AIDS
☐ Alcohol Addiction
☐ Alzheimer's
☐ Angina
☐ Anxiety
☐ Asthma
☐ Behavior
☐ Bleeding Disorder
☐ Blind
☐ Cancer
☐ Cardiac Dysrhythmia
☐ Cataracts
☐ Congestive Heart Failure
☐ Clotting Disorder
☐ COPD
☐ Coronary Bypass Graft
☐ Deaf
☐ Dementia
☐ Depression
☐ Diabetes/Insulin Dependent
☐ Diabetes/Non-Insulin
☐ Drug Addiction
☐ Epilepsy/Seizures
☐ Eye Surgery

☐ Other:_______________________

☐ Glaucoma
☐ Hard of Hearing
☐ Heart Valve Prosthesis
☐ Hemodialysis
☐ Hypertension
☐ Internal Defibrillator
☐ Irregular Heart Rhythm
☐ Kidney Failure
☐ Laryngectomy
☐ Leukemia
☐ Lung Disease/Emphysema
☐ Lymphomas
☐ Malignant Hypothermia
☐ Memory Impaired
☐ Mental Illness
☐ Myasthenia Gravis
☐ Pacemaker
☐ Previous Heart Attack
Date: _____________
☐ Pulmonary Hypertension
☐ Seizure Disorder
☐ Sickle Cell Anemia
☐ Stroke
☐ Tobacco Use
☐ Vision Impaired
☐ Other:_________

LANESBOROUGH AMBULANCE

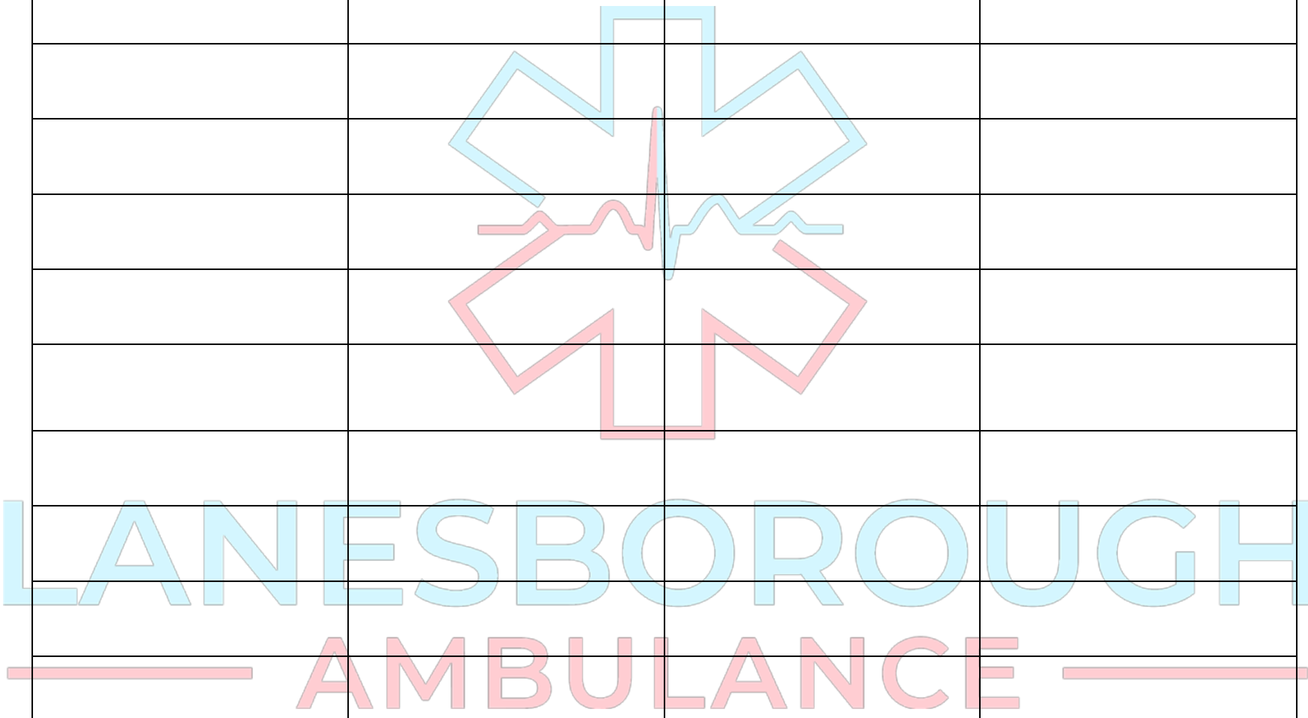
ALLERGIES

☐ No Known Allergies
☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Demerol
☐ Novocaine
☐ Morphine
☐ Environmental
☐ Horse Serum
☐ Insect Stings
☐ Latex
☐ Lidocaine
☐ Penicillin
☐ Sulfa
☐ Tetracycline
☐ X-Ray Dyes

Other: ____

MEDICATIONS

Medical Problem	Medication	Dosage	Frequency



Date of last tetanus shot: ______________________________

Date of last flu shot: ____________________

Date of last pneumonia shot___________________________

EMERGENCY CONTACTS
#1 NAME: ____

Address: _______________________________________

Relationship: __________Phone: _____________________

#2 NAME: ____

Address: ____

Relationship: __________Phone: _____________________

HEALTH INSURANCE INFORMATION

Medicare Number__________________________________

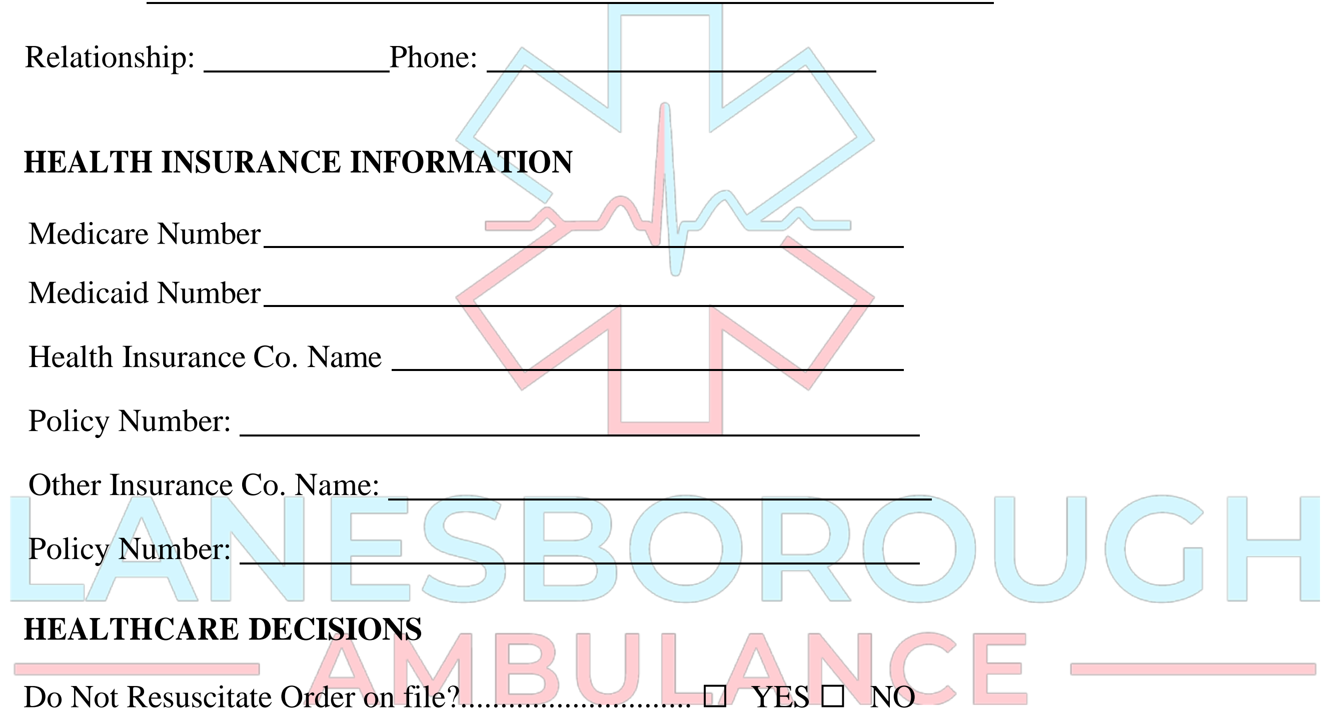
Medicaid Number__________________________________

Health Insurance Co. Name ___________________________

Policy Number: ____________________________________

Other Insurance Co. Name: ____________________________

Policy Number: ____________________________________



HEALTHCARE DECISIONS

Do Not Resuscitate Order on file?............................ ☐ YES ☐ NO

IF YES, Location: ________________________________

MOLST or Advance Directive on file?....................... ☐ YES ☐ NO

IF YES, Location: _____ ______________________________