



# Garland Fire Department

## Lifesaving Information For Emergencies

Use pencil to print information (it's easier to make updates & won't run if moist)

Give special attention to current medications & allergies. Please keep the form updated.

Date form completed: \_\_\_\_\_ (remember to change with each update to form)     Non-English Speaking

### PERSONAL DATA:

Name: \_\_\_\_\_

Sex: M / F

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Physician Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Secondary Physician Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Hospital Preferred: \_\_\_\_\_

### IN CASE OF EMERGENCY NOTIFY:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

### MEDICAL / INSURANCE DATA:

Primary Insurance Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Medicare Policy Number: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Medicaid Policy Number: \_\_\_\_\_

### Instructions:

**1. Fill out the form with pencil**

Answer all questions as best as possible.

**2. Place the form in a baggie**

You may also consider placing the following items in the baggie as well.

- DNR (Do Not Resuscitate)
- Living will or equivalent

**3. Attach form on outside of refrigerator door**

Use tape or magnet to attach baggie to door securely.

# Medical History / Conditions:

**Diagnosed or Treated for (check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Angina                               | <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Arthritis / Fibromyalgia  |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Bleeding / Clotting Disorder | <input type="checkbox"/> Cancer – Type: _____      |
| <input type="checkbox"/> Cataracts                            | <input type="checkbox"/> Congestive Heart Failure     | <input type="checkbox"/> COPD                      |
| <input type="checkbox"/> Dementia / Alzheimer’s               | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Emphysema                 |
| <input type="checkbox"/> Edema / Swelling                     | <input type="checkbox"/> Epilepsy / Seizures          | <input type="checkbox"/> Eye / Vision Impairment   |
| <input type="checkbox"/> Gall Bladder Disease                 | <input type="checkbox"/> Gastric Disease              | <input type="checkbox"/> Glaucoma                  |
| <input type="checkbox"/> Hearing Problems                     | <input type="checkbox"/> Heart Attack                 | <input type="checkbox"/> Heart Disease             |
| <input type="checkbox"/> Heart Murmur                         | <input type="checkbox"/> Hepatitis – Type: _____      | <input type="checkbox"/> Hiatal Hernia             |
| <input type="checkbox"/> High Blood Pressure                  | <input type="checkbox"/> HIV / AIDS                   | <input type="checkbox"/> Hypoglycemia (Low Sugar)  |
| <input type="checkbox"/> Jaundice                             | <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Low Blood Pressure        |
| <input type="checkbox"/> Liver Disease                        | <input type="checkbox"/> Respiratory Disease          | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Sickle Cell Anemia                   | <input type="checkbox"/> Stroke / CVA / TIA           | <input type="checkbox"/> Thyroid Disease           |
| <input type="checkbox"/> Tuberculosis                         | <input type="checkbox"/> Ulcers / GERD                | <input type="checkbox"/> Unable to Speak           |
| <input type="checkbox"/> Home / portable Oxygen LITERS: _____ |   | <input type="checkbox"/> Pacemaker / Defibrillator |
| <input type="checkbox"/> <u>NO</u> Medical Conditions         | <input type="checkbox"/> Other _____                  |  |

# Medications:

**Where do you keep medications:**

**List of Medications - currently taking - include dosage & frequency (ie Lasix - 20 mg)**

Medication Name:	Dosage:	Medication Name:	Dosage:

# Allergies:

**(check all that exist)**

- |  |                                  |                                       |                                     |
|--|----------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> <u>NO</u> Known Allergies | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine      | <input type="checkbox"/> Demerol    |
| <input type="checkbox"/> Insect Stings             | <input type="checkbox"/> Latex   | <input type="checkbox"/> Morphine     | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Sulfa                     | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Other: _____ |                                     |