

## **MEDICAL EMERGENCY CARD**

DATE:	MEDICATION	DOSAGE	FREQUENCY
NAME:			
YEAR OF BIRTH			
SOCIAL SECURITY #:			
PHYSICIAN & PHONE #:			
CONTACTS & PHONE#'S: (RELATIONSHIP)			
1			
2			
3			
MEDICAL HISTORY:			
LOCATION OF ADVANCED DIRECTIVIES			
(POLST, DNR, etc.)			

**OVER** 



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(POLST, DNR, etc.)			

## **MEDICAL CONDITIONS**

**CHECK ALL THAT APPLY** 

NO MEDICAL CONDITIONS ASTHMA	□ STROKE □ BLEEDING DISORDER	<ul><li>□ SEIZURE DISORDER</li><li>□ DIABETES/INSULIN DEPENDENT</li></ul>
HEART PROBLEMS	□ HYPERTENSION	
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STHMA EART PROBLEMS	CHECK ALL THAT A  STROKE BLEEDING DISORDER HYPERTENSION	APPLY
STHMA EART PROBLEMS	CHECK ALL THAT A	APPLY
ASTHMA HEART PROBLEMS	CHECK ALL THAT A	APPLY  - SEIZURE DISORDER - DIABETES/INSULIN DEPENDENT
ASTHMA HEART PROBLEMS	CHECK ALL THAT A	APPLY  - SEIZURE DISORDER - DIABETES/INSULIN DEPENDENT
ASTHMA HEART PROBLEMS	CHECK ALL THAT A	SEIZURE DISORDER DIABETES/INSULIN DEPENDENT
ASTHMA HEART PROBLEMS NO KNOWN ALLERGIES	CHECK ALL THAT A	SEIZURE DISORDER DIABETES/INSULIN DEPENDENT  DEPENDENT  DEPENDENT  DEPENDENT  DEPENDENT
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ASTHMA HEART PROBLEMS NO KNOWN ALLERGIES	CHECK ALL THAT A	SEIZURE DISORDER DIABETES/INSULIN DEPENDENT  DEPENDENT
ASTHMA HEART PROBLEMS HO KNOWN ALLERGIES	CHECK ALL THAT A	SEIZURE DISORDER DIABETES/INSULIN DEPENDENT
STHMA EART PROBLEMS  O KNOWN ALLERGIES	CHECK ALL THAT A	SEIZURE DISORDER DIABETES/INSULIN DEPENDENT
STHMA EART PROBLEMS  O KNOWN ALLERGIES	CHECK ALL THAT A	SEIZURE DISORDER DIABETES/INSULIN DEPENDENT
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