



# PERSONAL PLANNING FOR EMERGENCIES



## Aging and Disability Services

### 240-777-3000

## Fire & Rescue Safety Education

### 240-777-2430

**Use pencil to fill out one card for each person.**

**Fold card; insert in red magnetic pouch.**

**Place on refrigerator door. Update as changes occur.**

**Call with questions or for a NEW card.**

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

- |  |   |
|--|---|
| <input type="checkbox"/> No known medical conditions | <input type="checkbox"/> Eye Surgery            |
| <input type="checkbox"/> Abnormal EKG                | <input type="checkbox"/> Glaucoma               |
| <input type="checkbox"/> Adrenal Insufficiency       | <input type="checkbox"/> Hard of Hearing        |
| <input type="checkbox"/> AIDS                        | <input type="checkbox"/> Heart Valve Prosthesis |
| <input type="checkbox"/> Alcohol Addiction           | <input type="checkbox"/> Hemodialysis           |
| <input type="checkbox"/> Alzheimer's                 | <input type="checkbox"/> Hypertension           |
| <input type="checkbox"/> Angina                      | <input type="checkbox"/> Internal Defibrillator |
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Irregular Heart Rhythm |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Kidney Failure         |
| <input type="checkbox"/> Behavior                    | <input type="checkbox"/> Laryngectomy           |
| <input type="checkbox"/> Bleeding Disorder           | <input type="checkbox"/> Leukemia               |
| <input type="checkbox"/> Blind                       | <input type="checkbox"/> Lung Disease/Emphysema |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Lymphomas              |
| <input type="checkbox"/> Cardiac Dysrhythmia         | <input type="checkbox"/> Malignant Hypothermia  |
| <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Memory Impaired        |
| <input type="checkbox"/> Congestive Heart Failure    | <input type="checkbox"/> Mental Illness         |
| <input type="checkbox"/> Clotting Disorder           | <input type="checkbox"/> Myasthenia Gravis      |
| <input type="checkbox"/> COPD                        | <input type="checkbox"/> Pacemaker              |
| <input type="checkbox"/> Coronary Bypass Graft       | <input type="checkbox"/> Previous Heart Attack  |
| <input type="checkbox"/> Deaf                        | Date: _____                                     |
| <input type="checkbox"/> Dementia                    | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Seizure Disorder       |
| <input type="checkbox"/> Diabetes/Insulin Dependent  | <input type="checkbox"/> Sickle Cell Anemia     |
| <input type="checkbox"/> Diabetes/Non-Insulin        | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Drug Addiction              | <input type="checkbox"/> Tobacco Use            |
| <input type="checkbox"/> Epilepsy/Seizures           | <input type="checkbox"/> Vision Impaired        |
| <input type="checkbox"/> Other: _____                | <input type="checkbox"/> Other: _____           |

### ALLERGIES

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Environmental | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Horse Serum   | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Barbiturates       | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Latex         | <input type="checkbox"/> X-Ray Dyes   |
| <input type="checkbox"/> Demerol            | <input type="checkbox"/> Lidocaine     | <input type="checkbox"/> Morphine     |
| <input type="checkbox"/> Novocaine          |  |                                       |
| <input type="checkbox"/> Other: _____       |  |                                       |

