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

- ☐ 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
- ☐ Other:_____
- ☐ Eye Surgery
- ☐ 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:_____

_____

ALLERGIES

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

TO ACCESS **FILE OF LIFE**, GO TO

www.mcfrs.org/mcsafe

AND SEARCH FOR "FILE OF LIFE"