Medical Emergency Refrigerator Card

Name _____

Address _____

Emergency Contacts: 1. Name: _____ Phone _____

2. Name: _____ Phone _____

Date of Birth _____ Age _____ Hospital Preference _____

Primary Care Physician _____ Phone _____

Other Physician _____ Specialty _____ Phone _____

Typical Blood Pressure _____ / _____ Blood Type _____ Health Ins _____

Medications	Dosage	Frequency

-Please Post on Refrigerator-

(See reverse side)

Medical Emergency Refrigerator Card

Name _____

Address _____

Emergency Contacts: 1. Name: _____ Phone _____

2. Name: _____ Phone _____

Date of Birth _____ Age _____ Hospital Preference _____

Primary Care Physician _____ Phone _____

CURRENT MEDICAL CONDITIONS

(check all that exist)

- ☐ No Medical Conditions
- ☐ Abnormal EKG
- ☐ Adrenal Insufficiency
- ☐ Alzheimer's
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cardiac Dysrhythmia
- ☐ Coronary Bypass Graft
- ☐ Communicable Diseases:
- ☐ Communicable Diseases:
- ☐ Depression
- ☐ Diabetes
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Valve
- ☐ Hemodialysis
- ☐ Hemolytic Anemia
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Malignant Hypothermia
- ☐ Memory Impaired
- ☐ Myasthenia Gravis
- ☐ Pacemaker
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Situs Inversus
- ☐ Stroke or TIA
- ☐ Vision Impaired
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:

ALLERGIES *(check all that exist)*

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Ibuprofen/NSAIDS
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ X-rays/Dyes
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:

Please list any other important information the Fire Department should know:

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