Emergency Medical Information

**Complete the attached form and keep it in the Emergency Medical Information Kit’s plastic bag.**

You may choose to keep the bag on your refrigerator where trained emergency responders can find this information. If you need to go to the hospital or evacuate your home, you can take the 911SmartPak with you.

To print or download copies of this kit please visit: <http://mtdh.ruralinstitute.umt.edu/?age_id=6945>

**You may want to add these items to your Emergency Medical Information Kit:**

1. Recent photos of you, your family, and animals.
2. Your Living Will, Advanced Directive, Do Not Resuscitate orders (DNR), Physician Orders for Life Sustaining Treatment (POLST), or similar documents. These documents must be original and signed for emergency responders or doctors to act on your instructions.
3. A list of your current medications with the name of your pharmacy.

**Sign up for Smart911:**

Smart911 is available nationwide in towns that have chosen it for their 911 centers.   
Smart911 lets emergency responders briefly see your emergency medical information when you call from a telephone number that you link to Smart911 when you set up an account. This helps emergency medical services provide the best care for you.

The attached emergency medical information form was prepared by Smart911. You, a friend, or a care giver can use this information to make signing up for Smart911 easy.

To learn more, go to this website: [www.Smart911.com](http://www.Smart911.com)

**To learn more about how to prepare yourself and your family for emergencies and disasters, go to:** [**www.ready.gov/build-a-kit**](http://www.ready.gov/build-a-kit)

  

**Emergency Medical Information Form**

Effective date of plan:

Personal Information:

Name (First, Middle Initial, Last Names):

Home Address (Street, City, State, Zip code):

Home Phone Number (landline):

Cell/mobile Phone Number:

Email Address:

Date of Birth (Month, Day, Year):

You may provide a Pin # so the 911 Operator can verify your identity:

**Emergency contact persons *– at least one person who will check in on me in an emergency.***

Relationship:

Name (First, Middle Initial, Last Names):

Address (Street, City, State, Zip code):

Home Phone Number:

Cell Phone Number:

Email Address:

Primary Health Care Provider: Name/Number:

**Alternate Emergency contact persons*—someone different than the emergency contact above***

Relationship:

Name (First, Middle Initial, Last Names):

Address (Street, City, State, Zip code):

Home Phone Number:

Cell Phone Number:

Email Address:

**Alternate Emergency contact persons*-- someone different than the emergency contact above***

Relationship:

Name (First, Middle Initial, Last Names):

Address (Street, City, State, Zip code):

Home Phone Number:

Cell Phone Number:

Email Address:

**Quarantine Status for the COVID-19 virus:**

This individual is not quarantined

This individual voluntarily chose to self-quarantine

This individual was directed to self-quarantine by health professional

**Your current status:**

Healthy

Sick/showing flu-like symptoms

Recovered from flu-like symptoms

Other

Driver’s License Number:

Make/model/license plate number of vehicle(s):

Are you a trained, certified, or licensed healthcare worker? Yes  No

If yes, list your credentials/certifications/licenses:

Are you at risk of domestic violence? Yes  No

**This person has difficulty communicating in English (check all that apply):**

Unable to speak

Non-English Speaker  Language Spoken

**Physical Information:**

Male  Female

Height:

Weight:

Hair Color:

Eye Color:

Other physical description information:

**Blood Type:**

O+ O-  A+  A-  B+ B-  AB+  AB-

**Enclosed photos of**: Self  Family  Animals

Medical Information

**Allergies:**

**Indicate the type of prior reaction with an “M” for mild reactions and an “L” for potentially lethal reactions.** (Note: If you create a **Smart911 profile**, ‘\*’ replaces ‘L’ for potentially lethal reactions and ‘√’ replaces ‘M’ for mild reactions in this section.)

Prior Anaphylactic Reaction

Aspirin

Codeine

Demerol  
 Food Allergies

Horse Serum

Insect Stings

Latex  
 Lidocaine

Morphine

Novocain

Penicillin  
 Sulfa

X-ray dye

Other allergies:

**Breathing problems:**

Asthma

COPD

Congenital/chronic upper airway disease

Cystic fibrosis

Emphysema

Other breathing problems:

**Cancer:**

Leukemia

Lymphomas

Other cancer:

**Catheters & feeding tubes:**

Feeding tubes

Foley catheter

Intravenous lines

Medication port

If use any of the above, how frequently do these supplies require replacement?

Daily  
 2 times/week

weekly  
 every other week

monthly

**General Medical Conditions:**

Adrenal insufficiency

Alcoholism

Other Addiction

Blood clotting–disorder

Chronic pain  
 Depression

Diabetes

Eye surgery/Glaucoma

Hemophilia

Hypertension

Malignant hyperthermia

Muscular dystrophy

Myasthenia gravis

Renal failure/hemodialysis

Rheumatologic/joint problems

Sickle cell anemia

Situs inverse

Stroke

Suicide attempt

**Heart Disease:**

Aortic aneurysm

Angina

Cardiac dysrhythmia (abnormal heart rate)

Congenital heart Disease

Congestive Heart Failure (CHF)

Coronary artery bypass/angioplasty

History of heart attack/Myocardial infarction

History of myocarditis/Pericarditis/ heart infection

Pulmonary hypertension

**Implanted Medical Devices:**

Artificial joints

Cochlear implants(s)

Heart valve prosthesis/artificial heart valve

Implanted defibrillator

Left Ventricular Assist Device (LVAD)

Pacemaker

Tracheotomy

**Medical Therapies and Equipment:**

Home health care/visiting nurse/non-medical caregiver

Home health care/Visiting nurse/non-medical caregiver (around-the-clock):

In-home life sustaining medication or treatment

Requires airway suctioning

Uses oxygen tank

**Mobile Limitations:**

Amputee

Confined to bed

Electric wheelchair or scooter

Manual wheelchair  
 Paraplegia

Quadriplegia

Require walker, cane, or crutches

Require wheelchair

Weight over 300 pounds

Other mobility impairment:

**Neurological, Behavioral, Cognitive Conditions:**

Anxiety (extreme)

ADD/ADHD

Autism spectrum disorder

Bipolar disorder

Cerebral palsy

Cognitive impairment

Confused easily

Developmental disability

Difficulty understanding verbal or written instructions

Memory impaired, dementia, Alzheimer’s

Migraine or frequent headaches

Neurological disease

PTSD

Prone to wandering

Seizure disorder/epilepsy

Schizophrenia

Other psychiatric conditions:

**Neurological / Cognitive Behaviors:**

Crying all the time/often

Feeling irritable/angry

Feeling people touching me

Hearing things other people don’t hear

Hearing voices saying bad thing

Hearing voices say good or neutral things

Hearing voices telling me to do bad things

Hearing voices telling me to do good or neutral things

Hurting myself (cutting, ect.)

Isolating from others

Not Sleeping

Sensitive to loud noises/flashing lights

Tearful

Thoughts of suicide

**Organ transplants:**

Bone marrow

Bowel

Heart

Kidney

Liver

Lung

Pancreas

**Powered Medical Devices:**

Apnea monitor

IV pump

Kidney dialysis

Life sustaining medication requiring refrigeration

Nebulizer for breathing problems

Oxygen concentrator

Sleep apnea, CPAP, BRAP device

Ventilator/Respirator

### Other life-sustaining device or equipment dependent on electricity:

### **Prescription Medications:**

Antiarrhythmic

Antianginal

Anti-anxiety/sedative

Anticoagulant/blood thinner

Antihistamine (regular use)

Antimanic/mood stabilizers

Anti-psychotic

Barbiturates

Beta blocker

Chemotherapy

Diabetes medication (oral)

Erectile dysfunction medication

Immunosuppressant

Insulin

Opioids/Narcotics (regular use)

Steroid (oral)

Side Effect Control Medication

Other prescription medication:

**Sensory Impairments (vision, hearing and speech) and Assistive Technology:**

Blind

Low vision

Deaf/blind

Deaf

Hard of hearing

Speech impaired

Nonverbal

Braille

Computer

iPad

Hearing aids

Interpreter

Alternative communication device

**Other Medical information:**

Glasses or contact lenses:

Yes No

Organ donor:

Yes  No

Advance directive:

Yes  No

If yes, where is it located?

Hospital preference:

Main Direct Care or Support person(s) Name/Number:

Special Notes:

Medical Document: