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: