

MEDICAL EMERGENCY INFORMATION

Please place this card on the outside of your refrigerator

DATE COMPLETED

NAME:		MEDICATION	DOSAGE	FREQUENCY
DATE OF BIRTH:				
PHYSICIAN(S) NAME AND PHONE NUMBER				
1.				
2.				
3.				
CONTACT(S) NAME AND PHONE NUMBER				
1.				
2.				
3.				
SIGNIFICANT SURGERY				
OCATION OF ADVANCE DIRECTIVES (if applicable)				
DNR & POLST require additional forms. Check which form(s) you have				
□ DNR - Do Not Resuscitate				
☐ POLST - Physicians Orders for Life-Sustaining Treatmen	nt			
Please list location of DNR and POLST forms in box below:				
MEDICAL CONDITIONS (Check all that apply and list other	er cor	ditions Provide additional informat	ion helow)	
No medical conditions		Stroke	ion below)	
Asthma / COPD		Seizure Disorder		
□ Bleeding Disorder				
☐ Diabetes / Insulin Dependent				
☐ Heart Problems				
☐ Hypertension				
SEVERE ALLERGIES & DRUG REACTIONS (List any seve	re alle	ergies and/or drug reactions below)		
☐ No known allergies or reactions				
Please provide more details on medical conditions listed above a	nd/or	other information emergency responder	s should know:	
HOSPITAL PREFERENCE				

Web Site: cityofsalem.net/Departments/Fire

You might be transported to a different hospital based on your condition and/or hospital status.

Salem Fire Department 370 Trade St. SE Salem, OR 97301

Postage

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