

## 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:	
Primary Language:	Religion
Primary Doctor's Name:	
Doctor's Phone Number:	
CHECK ALL MEDICAL CO	NDITIONS THAT EXIST
<ul> <li>No known medical conditions</li> <li>Abnormal EKG</li> <li>Adrenal Insufficiency</li> <li>AIDS</li> <li>Alcohol Addiction</li> <li>Alzheimer's</li> <li>Angina</li> <li>Anxiety</li> <li>Asthma</li> <li>Behavior</li> <li>Bleeding Disorder</li> <li>Blind</li> <li>Cancer</li> <li>Cardiac Dysrhythmia</li> <li>Cataracts</li> <li>Congestive Heart Failure</li> <li>Clotting Disorder</li> <li>COPD</li> <li>Coronary Bypass Graft</li> <li>Deaf</li> <li>Dementia</li> <li>Depression</li> <li>Diabetes/Insulin Dependent</li> <li>Diabetes/Non-Insulin</li> <li>Drug Addiction</li> <li>Epilepsy/Seizures</li> <li>Other:</li> </ul>	<ul> <li>□ Eye Surgery</li> <li>□ Glaucoma</li> <li>□ Hard of Hearing</li> <li>□ Heart Valve Prosthesis</li> <li>□ Hemodialysis</li> <li>□ Hypertension</li> <li>□ Internal Defibrillator</li> <li>□ Irregular Heart Rhythm</li> <li>□ Kidney Failure</li> <li>□ Laryngectomy</li> <li>□ Leukemia</li> <li>□ Lung Disease/Emphysema</li> <li>□ Lymphomas</li> <li>□ Malignant Hypothermia</li> <li>□ Memory Impaired</li> <li>□ Mental Illness</li> <li>□ Myasthenia Gravis</li> <li>□ Pacemaker</li> <li>□ Previous Heart Attack</li> <li>□ Date:</li> <li>□ Pulmonary Hypertension</li> <li>□ Seizure Disorder</li> <li>□ Sickle Cell Anemia</li> <li>□ Stroke</li> <li>□ Tobacco Use</li> <li>□ Vision Impaired</li> <li>□ Other:</li> </ul>
ALLERO	CIEC
<ul> <li>□ No Known Allergies</li> <li>□ Aspirin</li> <li>□ Barbiturates</li> <li>□ Codeine</li> <li>□ Late</li> </ul>	rironmental

	MEDICATIO	NS	
Medical Problem	Medication	Dosage	Frequency
Date of last tetanus s	shot:		
Date of last flu shot:			
Date of last pneumo	nia shot:		
El	MERGENCY CO	NTACTS	
#1 NAME:			
Address:			
Relationship:	Phone:		
#2 NAME:			
#2 NAME:			
Address:			
Relationship:	Pnone: H INSURANCE I		
HEALH	I MOONANOL I	in onmanon	
Medicare Number: _			
Medicaid Number: _			
Health Insurance Co	. Name:		
Policy Number:			
Other Insurance Co.	Name:		
Policy Number:			
HE	EALTHCARE DE	CISIONS	
Do Not Resuscitate (	Order on file?	🗆 Y	′ES □ NO
IF YES, Location:			
MOLST or Advance I	Directive on file?	Y	ES NO
IF YES, Location:			

TO ACCESS FILE OF LIFE, GO TO www.mcfrs.org/mcsafe AND SEARCH FOR "FILE OF LIFE"