

ATTENTION PARAMEDICS

IMPORTANT MEDICAL INFORMATION

NAME _____ DOB _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CURRENT ILLNESSES/CONDITION

CURRENT PRESCRIPTION & NON-PRESCRIPTION
MEDICATION

PACEMAKER YES NO

PREFERRED HOSPITAL

ADDITIONAL DOCTOR INFO & PHONE NUMBER

1. _____
SPECIALTY _____
2. _____
SPECIALTY _____
3. _____
SPECIALTY _____

ALLERGIES TO ANY MEDICATIONS?

HOSPITALS WHICH HAVE YOUR RECORDS _____

MAJOR SURGERIES YOU HAVE HAD (MONTH/YEAR) _____

IN CASE OF EMERGENCY:

NAME _____

RELATIONSHIP _____

PHONE (1) _____

PHONE (2) _____

NAME _____

RELATIONSHIP _____

PHONE (1) _____

PHONE (2) _____

LIVING WILL YES NO DURABLE POWER OF ATTORNEY FOR HEALTH CARE YES NO

STATE OF OHIO COMFORT CARE ORDERS YES NO

DO NOT RESUSCITATE (DNR) ORDERS YES NO