MEDICAL EMERGENCY INFORMATION

Oregon State Fire Marshal

DATE COMPLETED: _____

NAME:

DATE OF BIRTH:

PHYSICIAN(S) NAME AND PHONE NUMBER

1. _____
2. _____

CONTACT(S) NAME AND PHONE NUMBER

1. _____
2. _____
3. _____

ADVANCED DIRECTIVES

- ☐ **DNR** *Do Not Resuscitate*
- ☐ **POLST** *Physicians orders for life-sustaining treatment*
- ☐ **POA** *Power of Attorney*

MEDICAL CONDITIONS

- ☐ No Medical Conditions
- ☐ Alzheimer's/Dementia
- ☐ Asthma/COPD
- ☐ Bleeding Disorders
- ☐ Diabetes/Insulin Dependent
- ☐ Heart Attack/Heart Problems
- ☐ Hypertension
- ☐ Renal Failure/Shunt
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Other _____

☐ Allergies

_____ _____

_____ _____

_____ _____

MEDICATIONS/SUPPLEMENTS/VITAMINS

Name: _____
Purpose: _____
Dose: _____
Frequency: _____
Prescriber: _____

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PLEASE PLACE THIS CARD ON THE OUTSIDE OF YOUR REFRIGERATOR.

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