EMERGENCY and MEDICAL INFORMATION

INDIVIDUAL'S NAME: _____

DATE OF BIRTH: _____

AN EPI-PEN IS REQUIRED FOR THE FOLLOWING ALLERGY: _____

EPI PEN LOCATION: _____

INSTRUCTION: _____

Note well: agency aides are not allowed by NYS regulation to provide an injection. Either the individual, a family member or neighbor would use the Epi Pen.

ALLERGY TO WHAT	REACTION		ALLERGY TO WHAT	REACTION

PRIMARY CARE DOCTOR: _____ PHONE NUMBER: _____

EMERGENCY CONTACT #1: _____ PHONE NUMBER: _____

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HOSPITAL OF CHOICE: _____

EMERGENCY PAPERS FOR AMBULANCE TEAM ARE KEPT ON TOP OF THE REFRIGERATOR. THESE INCLUDE:

_____ADVANCED DIRECTIVES (DNI; Do Not Intubate, DNR; Do Not Resuscitate)

OR….

_____ MOLST FORM (THIS IS A HOT PINK FORM COMPLETED WITH THE DOCTOR REGARDING LIFE SAVING MEASURES)

_____ COPY OF HEALTH CARE PROXY

_____ MEDICATION LIST with Allergies listed -TELL EMERGENCY TEAM ABOUT ANY BLOOD THINNERS

_____ DIAGNOSIS LIST

IS THIS PERSON A DIABETIC? ___ YES ___ NO

How often is the blood sugar checked: _____

Describe symptoms of low blood sugar: _____

INSTRUCTIONS: WHAT TO DO FOR LOW BLOOD SUGAR:

_____

_____

Describe symptoms of high blood sugar: _____

INSTRUCTIONS: WHAT TO DO FOR LOW BLOOD SUGAR:

_____

_____

DOES THIS PERSON GET AGITATED? ___ YES ___ NO

TRIGGERS: _____

WHAT HELPS: _____

_____

DOES THIS PERSON SUFFER FROM PAIN? ___ YES ___ NO

DESCRIBE WHERE: _____

WHAT HELPS: _____

_____

OTHER HEALTH CONCERNS FOR THIS PERSON AND INSTRUCTION: _____