EMERGENCY REFERENCE INFORMATION

Emergency Reference Card for Individuals with Medical Needs Living at Home & Their Caregivers			
Name:	DOB:	Blood Type:	
Street Address:	City:	State:	Zip Code:
Personal medical information that emergency responders need to know:			
Allergies I have:			
Medications I take:			
Prescription Name:	Dosage (for example, 50 mg)	Frequency (for example, twice per day)	
Vaccination Type:	Dose/Units:	Date Given (month/year)	
Special needs (e.g., eye glasses, hearing aids, mobility assistive devices, language translation needs, etc.):			

Emergency Phone Numbers (if not 911)

Local Dept:	Phone #	Emergency Contacts / Name		Phone #
Ambulance		Doctor		
Fire		Doctor		
Police		Doctor		
County Health		Clinic/Facilty		
Emergency Mgmt		Pharmacist		
Local Red Cross		Dentist		
Local Shelters		Veterinarian		

Family and Friends - Emergency Contacts

	Name	Phone		Name	Phone
Family Member		Home: Work: Cell:	Friend/Neighbor		Home: Work: Cell:
Family Member		Home: Work: Cell:	Friend/Neighbor		Home: Work: Cell:
Family Member		Home: Work: Cell:	Friend/Neighbor		Home: Work: Cell:
Family Member		Home: Work: Cell:	Friend/Neighbor		Home: Work: Cell:
Family Member		Home: Work: Cell:	Friend/Neighbor		Home: Work: Cell: