

## **Hampton Lakes Emergency Squad**

### **Vile of Life Program**

**Help us help you. Are you prepared for the next time you or your family member are in need of an ambulance. By completing the form on the opposite side of this sheet for each person in your home, you will always have the critical information the ambulance crew will need immediately available. After completing the information, place this sheet on the refrigerator or in the provided large medicine bottle in the refrigerator on the door, we are trained to look for this information at the refrigerator.**

**Additional items to have available if you should need an ambulance are your state issued ID such as a driver's license, insurance cards, if you have them, social security card and Medicare card if your Medicare ID does not end with an A. You may also copy the cards to the bottom of this page or fill in the information on the reverse side.**

**Thank you for allowing us to assist you in your time of need.**

**Dial 911 for Emergencies**

**Call 888-240-1780 for Questions**

List any other information you think is important in the space below:

*Complete this page in pencil for easy updating.*

**KEEP MEDICAL INFORMATION UP TO DATE**

Review and update as needed every six month: Date completed: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

Telephone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**MEDICAL HISTORY**

Please circle any item below you have been diagnosed with by a physician

Anxiety      Heart Problems - Specify: \_\_\_\_\_ Hypertension      Stents      Atrial Fibrillation

COPD      Emphysema      Asthma      Chronic Bronchitis

CANCER Specify: \_\_\_\_\_

Other: \_\_\_\_\_

**MEDICATIONS**

Please list medication name and dosage

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to medications/food: \_\_\_\_\_

Do you have an advanced directive about your care?    YES / NO      Where is it located? \_\_\_\_\_

Do you want CPR? YES / NO

**EMERGENCY CONTACTS**

Next of Kin / Family / Friend : \_\_\_\_\_ Telephone #: \_\_\_\_\_

Other: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Blood Type: \_\_\_\_\_

Religion: \_\_\_\_\_

**MEDICAL INSURANCE**

PRIMARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

MEDICARE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Complete this page in pencil for easy updating.*