EVERYTHING YOU NEED TO KNOW IS IN THIS BINDER

EMERGENCY MEDICAL JOURNAL

Name:_____

Date of Birth:_____**Blood Type:**_____

Cover Page

Name:_____

DOB:_____

Blood Type: _____

Power of Attorney: _____ _____
Name Phone

Do you have a DNR: Yes or No

Intubation: Yes or No Signature & Date: _____

Defibrillation: Yes or No Signature & Date: _____

ICE (In Case of Emergency) Contact:

Name: _____Phone: _____

Primary Physician:

Name: _____Phone: _____

***Last Updated:* _____**

Current Physicians and Pharmacies

Name, Specialty, Contact Information, Hospital Affiliation, and Pharmacies

Physicians

Physician:_____ Specialty:_____

Phone:_____ Hospital Affiliation:_____

Physician:_____ Specialty:_____

Phone:_____ Hospital Affiliation:_____

Physician:_____ Specialty:_____

Phone:_____ Hospital Affiliation:_____

Physician:_____ Specialty:_____

Phone:_____ Hospital Affiliation:_____

Physician:_____ Specialty:_____

Phone:_____ Hospital Affiliation:_____

Pharmacies

Pharmacy:_____ Phone:_____

RX #:_____

Pharmacy:_____ Phone:_____

RX #:_____

Last Updated:_____

Allergies

Life Threatening: (Type and Reaction, ie: Penicillin & anaphylactic shock)

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Last Updated:_____

Allergies

Non-Life Threatening: (Type and Reaction)

Allergy:_____Reaction:_____

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Allergy:_____Reaction:_____

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Allergy:_____Reaction:_____

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Allergy:_____Reaction:_____

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Allergy:_____Reaction:_____

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Last Updated:_____

Medications

Record short and long term meds, update as needed

Breakfast

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Lunch

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Bedtime

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Last Updated:_____

Supplements & Vaccinations

Supplements

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

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Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Name:_____ Dosage:_____ Time:_____

Vaccinations

Vaccine Name:_____ Date Received:_____

Vaccine Name:_____ Date Received:_____

Vaccine Name:_____ Date Received:_____

Vaccine Name:_____ Date Received:_____

Vaccine Name:_____ Date Received:_____

Vaccine Name:_____ Date Received:_____

Vaccine Name:_____ Date Received:_____

Last Updated:_____

Medical History

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Surgery:_____ Date:_____

Physician:_____ Hospital:_____

Last Updated:_____

Additional Medical History

Last Updated:_____

ICE (In Case of Emergency)

Additional Contact Phone Numbers

ICE (In Case of Emergency): In order of importance:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Power of Attorney

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Additional Personal Contacts

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

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Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Last Updated:_____

Personal Info, Habits & Preferences

Loved One's Name:_____ Date of Birth:_____

Current Address:_____

_____

Insurance Information

Company Name:_____ Phone:_____

Policy Number:_____ Group Number:_____

Medicare/Medicaid Number:_____

Supplemental Policy: _____ Phone:_____

Policy Number:_____ Group Number:_____

Personal Info, Habits & Preferences

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Last Updated:_____