HELP! Medical Emergency Information

Date last revised: _____

Help the Albany Fire Department help you in an emergency

1. Photocopy this 2-sided form so there is one for each person in your household. If you prefer to print copies, this form can be downloaded from the Fire Department website at: www.albanyca.org/fire.

2. Fill out this form using a ballpoint pen.

3. Fold the form into fourths along the dotted lines on this page, folding first on the horizontal line, then on the vertical line, so that the words "HELP! Medical Emergency Information" are visible when you place the completed form into a Ziploc®-type plastic sandwich bag.

4. Tape the plastic bag to the outside of your refrigerator so emergency medical responders will be able to find this information in a medical emergency.

5. If your doctor has signed a Do Not Resuscitate (DNR) form or a Physician Orders for Life-Sustaining Treatment (POLST) form, place a copy of the DNR or POLST form in the plastic bag along with the completed HELP! form.

6. Update as medical conditions, medications, and other information changes.

The Albany Rotary Club and the Albany Fire Department have collaborated to bring you the Help! Medical Emergency Information Program

Designed by Albany Fire Fighters, this form will enable First Responders to provide the best possible emergency medical care to the citizens of Albany.

A completed and current form provides Paramedics with your emergency medical and contact information in the event you are unable to give them that vital information.

After reading the directions above, please complete the form, place it in a plastic baggy, and then tape it to the front of your refrigerator. Remember to update it as necessary.

ALBANY ROTARY

PLEASE PRINT CLEARLY IN CAPITAL LETTERS

Update Date:	Health Insurance Co.:	Insurance Policy #:

Copy of Your DNR or POLST Form Enclosed: ☐ Yes ☐ Not Applicable	Identifying Marks (Birthmarks, Scars, Tattoos, etc.):

First Name:	Last Name:	☐ Male ☐ Female

Date of Birth:	Language (if not English):	Developmental Disabilities:

Allergies	☐ Penicillin ☐ Aspirin ☐ Latex ☐ Sulfa Other drugs: _____ Other allergies: _____
Medical Conditions	☐ Asthma ☐ Epilepsy ☐ Dementia (Type): _____ ☐ Diabetes ☐ Lung Disease ☐ Stroke Deficits: _____ ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer (Type): _____ ☐ Hearing Loss ☐ Other: _____

Medications (Use additional paper if needed): ☐ Heart Disease Medication: _____ ☐ Respiratory Disease Medication: _____ ☐ Other Medications: _____	☐ Pacemaker	☐ Internal Defibrulator

Primary Emergency Contact	Name:	Home Phone:	
	Cell:	Work Phone:	Relationship:

Additional Emergency Contact (Neighbor)	Name:	Home Phone:	
	Cell:	Work Phone:	Relationship:

Primary Care Physician	Name:	Phone:	Name of Practice:

Pets:	Name and Telephone Number of person to contact for pet care: