



## EMERGENCY RESPONDER INFORMATION

Date: \_\_\_\_\_

In case of emergency: dial 9-1-1. To contact the Squad, dial 973-377-1131.

The information in this form will allow emergency personnel to help you more efficiently in an emergency. Fold the form and place it in the vial provided. Place the packet on the upper right shelf in the refrigerator. Put the magnet on the outside of the refrigerator to let EMS know the information is available. Use a separate form for each person.

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Birth date: \_\_\_\_\_

Church: \_\_\_\_\_ Clergy: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Heart problems?  Yes  No High Blood Pressure?  Yes  No

Respiratory problems?  Yes  No Hearing Aids?  Yes  No

Pacemaker?  Yes  No Diabetes?  Yes  No

Dentures?  Yes  No Glasses?  Yes  No

Additional Medical Problems: \_\_\_\_\_

Living Will?  Yes  No Located where? \_\_\_\_\_

DNR?  Yes  No Located where? \_\_\_\_\_

Blood Type (if known): \_\_\_\_\_ Allergies (specify): \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred hospital: \_\_\_\_\_

### Medications

Name and dosage: \_\_\_\_\_ Name and dosage: \_\_\_\_\_

Name and dosage: \_\_\_\_\_ Name and dosage: \_\_\_\_\_

Name and dosage: \_\_\_\_\_ Name and dosage: \_\_\_\_\_

Name and dosage: \_\_\_\_\_ Name and dosage: \_\_\_\_\_

Epipen?  Yes  No Located where? \_\_\_\_\_

Signature: \_\_\_\_\_