EMERGENCY INFORMATION FORM

Update when your information changes. Review the form at least every six months when you change the time on your clocks. If you need a new form, scan the code to the left with your smart phone or visit http://aging.dhs.georgia.gov/yellow-dot-program.

Use of this form is voluntary. By using this form, you understand that first responders and medical personnel will use this information as they see fit.

DATE
___/___/___

Personal Information *Please print legibly.*

Last Name: First Name: MI:

☐ Female ☐ Male Height: Weight: Primary Language:

Address: City: State: Zip:

Emergency Contact 1: Relationship: Phone:

Emergency Contact 2: Relationship: Phone:

Primary Doctor: Phone:

Pharmacy: Phone: ☐ Organ Donor

☐ Advance Directive, Living Will or POLST (If not in Yellow Dot packet, include document location in the yellow OTHER IMPORTANT INFORMATION box at the bottom of this page)

Medical History *Check all boxes that apply to you. Please print legibly.*

Medical Conditions *Indicate all past and present health conditions.*

Heart Conditions

- ☐ Heart Rhythm/AFIB/ Abnormal Heart Rate
- ☐ Angina/Chest Pain
- ☐ Defibrillator/Pacemaker
- ☐ Heart Attack
  Date of Last __/__/__
- ☐ Heart Failure/CHF
- ☐ Heart Valve Replacement
- ☐ High Blood Pressure

Brain/Nervous System Conditions

- ☐ Anxiety
- ☐ Dementia/Alzheimers
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Stroke/TIA

Auto-Immune Conditions

- ☐ Hepatitis
- ☐ Lupus
- ☐ HIV/AIDS
- ☐ Myasthenia Gravis

Lung Conditions

- ☐ Asthma
- ☐ COPD/Emphysema

Sensory Impairments

- ☐ Visually Impaired/Blind
- ☐ Hearing Impaired/Deaf

Other Medical Conditions:

- ☐ Bleeding/Clotting Disorder
- ☐ Cancer (Type:__________)
- ☐ Currently Pregnant
  Due Date: __/__/__
- ☐ Diabetes
- ☐ Dialysis/Kidney
- Ÿ Sickle Cell Disease
- ☐ Tuberculosis
- ☐ Last Tetanus Shot
  Date: __/__/__
- ☐ Other________________
  ____

Health Habits

- ☐ Tobacco Use
  Type________________
- ☐ Alcohol Use
  _____times per ___________
- ☐ Illicit Drug Use
  Type(s):________________
  ____

Allergies *Indicate all allergies and reactions (rash, hives, swelling of the face or tongue, wheezing/trouble breathing, etc.)*

- ☐ No Known Allergies
- ☐ Latex
  Reaction:________________
- ☐ X-ray Dyes
  Reaction:________________
- ☐ Foods
  Type(s):________________
  Reaction:________________
  ____
- ☐ Insect Stings
  Type(s):________________
  Reaction:________________
- ☐ Medications
  - ☐ Aspirin
    Reaction:________________
  - ☐ Penicillin
    Reaction:________________
  - ☐ Morphine
    Reaction:________________
  - ☐ Other Medication(s)
    Type(s):________________
    ____
    Reaction: ________________
    ____
- ☐ Other Allergies
  Type(s):________________
  ____
  Reaction:________________

Major Surgeries (Types and Date): ________________
____
____
____
____

Other Important Information: ________________
____
____
____
____

This Yellow Dot Program is made possible by the Georgia Department of Human Services, Division of Aging Services, the Georgia Department of Public Health, the Governor's Office of Highway Safety and Alliant Georgia Medical Care Foundation. All information contained is the sole responsibility of the participant or participant's agent.

This document contains Emergency Information for:

Participant Name: ____________________

Year of Birth: ____________________

Enrollment Site: ____________________

Medications

Indicate all prescription and over-the-counter medications, vitamins and supplements along with dose and directions. Update this list whenever your medications change. Add additional pages if needed. Please print legibly. **Example:** Aspirin 81mg once daily

DATE __/__/__

Medication	Dose	Directions
Vitamins & Supplements	**Dose**	**Directions**