



Mundelein Fire Department

File For Life

Name: _____ M F Phone: _____

Address: _____

Religious Preference: _____

Emergency Contacts

Name: _____ Phone: _____

Address: _____

Relationship: _____

Name: _____ Phone: _____

Address: _____

Relationship: _____

Medical Information

Last Updated: _____

Doctor: _____ Phone: _____

Doctor: _____ Phone: _____

Medications Taken Daily

<u>Medication Name</u>	<u>Dosage</u>	<u>How Often You Take It</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Name

Dosage

How Often You Take It

Medical Procedures / Surgeries

Surgery / Procedure Done

Date Performed

Important Medical Documents
A Copy Should Of These Should
Be Kept With This for Paramedics and
Hospital Staff

Living Will: Yes No Power of Attorney for Health: Yes No

DNR: Yes No

Medical Conditions

- | | |
|--|--|
| <input type="checkbox"/> None Known | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hepititis / Type _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypertension / High BP |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hyportension / Low BP |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Memory Impairment |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke / Date _____ |
| <input type="checkbox"/> Heart Attack / Date _____ | <input type="checkbox"/> TB |

Allergies

- | | |
|--|--|
| <input type="checkbox"/> None Known | <input type="checkbox"/> Lidocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Barbituate | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Codine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Evironmental ie Dust/Grass etc. | <input type="checkbox"/> Tetracycline. |
| <input type="checkbox"/> Horse Serum | <input type="checkbox"/> X-Ray Dyes |
| <input type="checkbox"/> Insect Sings | <input type="checkbox"/> Other _____ |

Medical Insurance Information

Insurance Company: _____

Policy Number: _____

Insurance Company: _____

Policy Number: _____

Medicare Information: _____

Medicaid Information: _____

Any Other Information You Feel Is Important

Please make sure you keep this information up to date. You can fill out a new one on our website www.mundeleinfire.org or contact us at 847-949-3260 and we will let you know where you can pick up. If you would like assistance filling this form out you please contact and we will arrange for someone to come out and assist you.

Thank you for helping us help you.