SOUTH METRO FIRE RESCUE COLORADO

www.SouthMetroCRR.org

Name: _____ Sex M F
Address: _____
_____
_____
Date of Birth: ____ / ____ / _____

EMERGENCY CONTACTS

Name:
_____
Address:
_____
Relation:
_____
Name:
_____
Address:
_____
Relation:
_____

MEDICAL DATA

Last Updated: Mo. ____ Yr. ____ Blood Type: _____

Doctor: _____ Phone: _____

Preferred Hospital: _____

Religion: _____

Recent Surgery: _____ Date: _____
_____
_____

Living Will on file at: _____
Health Care Proxy on file at: _____

Do you have a EMS NO-CPR Directive or DNR form? YES ☐ NO ☐
** Place copy of directive in file of life magnet on refrigerator*
Special Conditions/Remarks for SMFR Crews:
_____
_____
_____
_____
_____

MEDICAL CONDITIONS

- ☐ Cancer
- ☐ Cardiac Dysrhythmia
- ☐ Cataracts
- ☐ Clotting Disorder
- ☐ Coronary Bypass
- ☐ Graft
- ☐ Dementia
- ☐ Alzheimers
- ☐ Diabetes/Insulin
- ☐ Dependent
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Hearing Imparied
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Memory Impaired
- ☐ Myasthenia Gravis
- ☐ Pacemaker
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision Impaired
- ☐ Other: _____
- ☐ Other: _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Ray Dyes
- ☐ None Known
- ☐ Environmental: _____
- ☐ Other: _____

MEDICAL INSURANCE

Med Ins. Co: _____
Policy #: _____
Other Med Ins Co: _____
Policy #: _____
Medicaid #: _____Medicare#: _____

Medication	Dosage	Frequency