

Newton NH Fire Department

The Newton NH Fire Department is offering to seniors with medical issues a form you can fill out and place on your refrigerator. The form can be used by emergency personnel to better assist you in an emergency. Stop by the new Fire/Rescue Station at 8 Merrimac Road or the Town Hall for the form and magnetic holder.

KEEP INFORMATION UP TO DATE !!
Review At Least Every Six Months !

MEDICAL DATA REVIEWED AS OF _____ **MO.** _____ **YR.** _____

Name: _____ **Sex:** _____
M F

Address: _____

Doctor: _____ **Phone #:** _____

Preferred Hospital: _____

EMERGENCY CONTACTS

Name: _____ **Phone #:** _____

Address: _____

Name: _____ **Phone #:** _____

Address: _____

MEDICAL DATA

Use pencil for ease in making changes.

Special Conditions/Remarks: _____

Medication	Dosage	Frequency

Pharmacy: _____ **Phone:** _____

Date of Birth: _____

Blood Type: _____ **Religion:** _____

Health Care Proxy on file at: _____

Living Will on file at: _____

@ FILE OF LIFE **SEE BACK OF CARD FOR ADDITIONAL INFORMATION**

<p>Recent Surgery: _____</p>	<p>Date: _____</p>
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Do you have an EMS-NO CPR Directive or a DNR form ?
YES ☐ **NO** ☐ **Where is it located ?** _____

MEDICAL CONDITIONS

Check all that exist

<input type="checkbox"/> No known medical conditions <input type="checkbox"/> Abnormal EKG <input type="checkbox"/> Adrenal Insufficiency <input type="checkbox"/> Angina <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac Dysrhythmia <input type="checkbox"/> Cataracts <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Coronary Bypass Graft <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> <input type="checkbox"/> Diabetes/Insulin Dependent <input type="checkbox"/> Eye Surgery <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Heart Valve Prosthesis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> Hemolytic Anemia <input type="checkbox"/> Hepatitis-Type [] <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Laryngectomy <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphomas <input type="checkbox"/> Memory Impaired <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Renal Failure <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Vision Impaired
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ALLERGIES

<input type="checkbox"/> Aspirin <input type="checkbox"/> Barbiturate <input type="checkbox"/> Codeine <input type="checkbox"/> Demerol <input type="checkbox"/> Horse Serum <input type="checkbox"/> Environmental: <input type="checkbox"/> Other: _____	<input type="checkbox"/> Insect Stings <input type="checkbox"/> Latex <input type="checkbox"/> Lidocaine <input type="checkbox"/> Morphine <input type="checkbox"/> Novocaine	<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfis <input type="checkbox"/> Tetracycline <input type="checkbox"/> X-Rays Dyes <input type="checkbox"/> No Known Allergies
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MEDICAL INSURANCE

Med Ins Co: _____

Policy #: _____

Other Med Ins Co: _____

Policy #: _____

Medicaid #: _____ **Medicare #:** _____