EMERGENCY PREPAREDNESS TOOLKIT
MEDICAL EMERGENCY WALLET CARD FOR:

NAME: ____________________________________________________________

DATE OF LAST UPDATE: __________/___________

Complete both sides of this card using a pencil. Update the information every six months. Keep the card with you at all times (in your wallet or purse). Keep an extra copy in your GO BAG.

PERSONAL DATA
Name: ________________________________________________________________
Address: __________________________________________________________________
City: __________________________________________________________________
State: __________ Zip: ________________________________________________________
Phone: _________________________________________________________________
Email: _________________________________________________________________
Date of Birth: ______________ Blood Type: ________________________________
Religion: ________________________________________________________________

Physical Disability/Mobility Impairment Specific Needs:
☐ I have a physical disability (identify): ________________________________
☐ I need a patient lift to transfer
☐ I use assistive technology
☐ I use a cane, walker or crutches
☐ I need help with medications
☐ I need a personal care attendant
☐ I use a manual wheelchair
☐ I use a scooter/power wheelchair
☐ I need my communication device
☐ I am Deaf
☐ I am hard-of-hearing
☐ I can read lips
☐ I need a sign language interpreter
☐ I am claustrophobic
☐ I am a wanderer
☐ I have memory problems
☐ I have allergies
☐ I need my EpiPen
☐ I am blind
☐ I am visually impaired
☐ I can read braille
☐ I need glasses
☐ I am sensitive to EMFs
☐ I have chemical sensitivities/MCS
☐ I have breathing problems
☐ I need my inhaler
☐ I aspirate/choke
☐ I am deaf
☐ I am hard-of-hearing
☐ I can read lips
☐ I need a sign language interpreter
☐ I am claustrophobic
☐ I am a wanderer
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☐ I have chemical sensitivities/MCS
☐ I have breathing problems
☐ I need my inhaler
☐ I aspirate/choke

MEDICAL DATA
Doctor’s Name: _______________________________________________________
Doctor’s Phone: _______________________________________________________
Preferred Hospital: _____________________________________________________

Location(s) of Health Care Power of Attorney and/or Living Will:

What is a Health Care Power of Attorney? This is a legal document that allows someone you choose to make decisions about your medical care if you are not able to. This choice is made before you get sick so you can pick someone you trust.

What is a living will? This is a legal document that you can use to explain what you want and don’t want. It explains what type of medical treatment and life-saving measures you want or don’t want.

Visit www.dhs.wisconsin.gov/forms/advdirectives for more information.
MEDICATIONS

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<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Time(s)</th>
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Pharmacy: __________________________________________________________

Phone: _______________________________________________________________

MEDICAL CONDITIONS

List any medical conditions:
____________________________________________________________________
____________________________________________________________________

Allergies: ___________________________________________________________
____________________________________________________________________
____________________________________________________________________

Recent surgeries and dates: ___________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ____________________________________________

Phone: _______________________________________________________________

Out-of-town Contact Name: ___________________________________________

Phone: _______________________________________________________________

Durable Medical Equipment Provider: _________________________________

Phone: _______________________________________________________________

Meeting Place: _______________________________________________________

Address: ____________________________________________________________

City: ___________________ State: ___________ Zip: ___________________

Phone: _______________________________________________________________

MEDICAL INSURANCE

Medical Insurance Company: _________________________________________

Policy Number: ____________________________________________________

Phone: _______________________________________________________________

Other Medical Insurance: _____________________________________________

Policy Number: ____________________________________________________

Phone: _______________________________________________________________

Medicaid Number: ___________________________________________________

Medicare Number: _________________________________________________

This wallet card is part of the Wisconsin Council on Physical Disabilities Be Prepared, Have a Plan: Emergency Preparedness Toolkit, made possible by the FEMA 2012 Community Resilience Innovation Challenge grant and by the Wisconsin Division of Public Health Emergency Preparedness (PHEP) program.