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:____

Check all that apply:

❍ I have a physical disability (identify): ____________________________

❍ I use a wheelchair

❍ I use a scooter/power wheelchair

❍ I need a patient lift to transfer

❍ I use a cane, walker or crutches

❍ I need assistive technologies

❍ I need help with medications

❍ I have allergies:_______________

❍ I need my EpiPen

❍ I have breathing problems

❍ I need my inhaler

❍ I need a personal care attendant

❍ I aspirate/choke

❍ 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 Visually Impaired

❍ I need glasses

❍ I am Blind

❍ I can read braille

❍ I am claustrophobic

❍ I am a wanderer

❍ I have memory problems

❍ I have chemical sensitivities/MCS

❍ I am sensitive to EMFs

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.

MEDICAL INSURANCE

Medical Insurance Company: ______________________________

Policy Number: ______________________________

Phone: ______________________________

Other Medical Insurance: ______________________________

Policy Number: ______________________________

Phone: ______________________________

Medicaid Number: ______________________________

Medicare Number: ______________________________

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: ______________________________

MEDICATIONS

Medications	Dosage	Frequency

Pharmacy: ______________________________

Phone: ______________________________

MEDICAL CONDITIONS

List any medical conditions and/or allergies: ______________________________

____

____

Recent Surgeries: ______________________________

____

____

Dates: ______________________________

____

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.