

PARAMEDIC ONE-PAGER

PARAMEDIC ONE-PAGER

Binder Of a Lifetime com

WWW. Binder of a Lifetime com



Name:	Date of Birth:	
Street Address, Zip:		
	ne Phone#: Cell Phone#:	
Gender: Height: Weight:		
Other Info / Distinguishing Characterist	ics:	
Circle/Fill In All That Apply		
Heart Attack (year of last):	Stroke	Emphysema
Congestive Heart Failure	Angina	Asthma
High Blood Pressure	Diabetes	Bleeding Ulcer
Seizures	Osteoporosis	Bronchitis
Pacemaker Model #	Defibrillator Model #	
Hearing Aid? L R Deaf? L R Vision:	Glasses Contact Lenses	Artificial Eye? L R
Doctor's Name:	Office Phone#:	
Currently Being Treated For:		
Current Medications and Dosage:		
Medication Allergies:		
Have Living Will? Y N Copy of Living W	/ill at Doctor's Office? Y	N
Living Will Primary Contact Name:	Pho	one# :
Have Health Care Power of Attorney? Y		
Phone#: Second C		
Organ Donor Contact (if applicable):		
Medical Coverage Medicare/Medicaid	#:	
Other Company Policy Name:		
Engage and Camback		
Emergency Contact	5.1	1.
	Relationship:	
	Cell Phone#:	
	Cell Phone#:	
Religious Contact:	Phone#:	

Use a magnet to place this folded, completed document on your refrigerator