Emergency Medical Information Form

Instructions for completing Form

In event of a medical emergency, this Form will provide Emergency Medical Service (EMS) Personnel with vital information about your medical history and current medications. A Resident Emergency Preparedness decal on your window will alert EMS to the location of your Form.

You may complete a paper copy of the Emergency Medical Information Form or download, save, and complete the Form on your computer.

1. **Complete a paper copy of the Emergency Medical Information Form:**
   - Go to the Sun City website at www.sctexas.org/EMC and log in.
   - From the Emergency Management Committee web site, choose Documents from the list on the right and then select Emergency Medical Form.
   - Click on **View** to see and print the Form or **Download** to save the Form to your computer.
   - If you downloaded the Form, open it, give it a new name and save it in a file on your computer. You can now fill out the Form on your computer, save it, and print a paper copy. This will allow you to go back anytime and update the Form. Complete a Form for each member of the household.
   - Paper copies are also available at the Texas Drive Social Center Monitor's desk.
2. Place a copy of your completed Emergency Medical Information Form inside a plastic zip lock or red bag. You may also want to include copies of additional information such as:
   - Health Insurance Card(s)
   - Advance Directive (aka Directive to Physician or Living Will)
   - A photo of yourself (i.e. Driver's License or ID Card)
   - Emergency Contact Information Form
3. Securely tape the plastic Ziploc or red bag containing your documents and forms in easy view inside/or on your refrigerator.
4. **Obtain a Resident Emergency Preparedness decal** (you only need 1) from the Monitor's Desk at the Texas Drive Social Center. Place the decal on a window closest to your front door where it can be easily seen by EMS personnel or others responding to an emergency.

Sun City Texas Community Association

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Date Completed:			
Name		**Date of Birth:**	
Address:		**Phone Number:**	
Doctor's Name:		**Phone Number:**	
Emergency Contact:		**Phone Number:**	
Contact Relationship		**Hospital Preference:**	
Primary Language Other Than English:			

Known Physical Conditions (check all that apply):

- ☐ Deaf
- ☐ Hard of Hearing
- ☐ Hearing Aid
- ☐ Blind
- ☐ Diminished Vision
- ☐ Eyeglasses/Contacts
- ☐ Speech Impaired

Drug Allergies:	
Other Allergies:	
Latex Allergy:	☐ = Yes ☐ = No

History of Health Conditions (check all that apply):

- ☐ Chest Pain
- ☐ Heart Attack
- ☐ CHF
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Breathing Problem
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Seizures
- ☐ Cancer
- ☐ Kidney Dialysis
- ☐ Bleeding Disorder
- ☐ Cognitive Disorder
- ☐ Artificial Limb
- ☐ Joint Replacement
- ☐ Other

Special Needs (check all that apply):

- ☐ Oxygen
- ☐ Cane / Crutches
- ☐ Walker
- ☐ Wheelchair
- ☐ Bedridden
- ☐ Other: Please Specify_____

Location of Medications:_____

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RESIDENT EMERGENCY PREPAREDNESS

Medication List for: Date: mm/dd/yyyy

List **all** prescription medications and **all** Over-the-Counter medications and supplements you are currently taking.

Prescription Medication	Strength	Frequency	Time

Over-the Counter medications and supp. (e.g. aspirin, ibuprofen, vitamins)	Amount	Frequency	Time