Charlotte County Red Dot Medical Information

Personal Information

Phone:________________ Emergency Key Location/Key Pad Code:________________ Date:_________________
Name:____ Date of Birth:_____________Age:__________________
Address:______________________Unit:______City:_______________________FL Zip Code:________________
Sex: M☐ F☐ Weight:________ Blood Type:_____ Organ Donor: Y☐ N☐ Language:_______________________
Hospital Preference:_________________________ Doctor:______________________ Phone #:______________
Do Not Resuscitate Order (DNRO): Y☐ N☐ Living Will: Y☐ N☐

Medical History

Cardiac: Y☐ N☐ Type:____ Pacemaker: Y☐ N☐
Respiratory Problems Y☐ N☐ Type:____
Stroke: Y☐ N☐ Deficits:____
Immobility: ☐Cane☐Walker☐Wheelchair☐Bed bound☐Other____
Blood Pressure ☐ High ☐Low Dentures: ☐Upper ☐Lower ☐Both
Cancer: Y☐ N☐ Type:__________________________________ Diabetic: Y☐ N☐ Insulin Dependent: Y☐ N☐
Past Injuries/Surgeries:____

☐ Epilepsy/Seizures	☐ Glasses	☐ Glaucoma	☐ Hearing Impairment
☐ Dementia/Alzheimer's	☐ Contact Lenses	☐ HIV	☐ Deaf
☐ Kidney Dialysis	☐ Vision Impairment	☐ Aids	☐ Hearing Aid
☐ Hepatitis	☐ Blind	☐ TB	☐ Anemia

Medications & Supplements

Name of Medication	Dosage	Times Per Day
____	________________	__________________
____	________________	__________________
____	________________	__________________
____	________________	__________________

Allergies: ____
☐ Check the box if you have a separate list of medications. Location of list______________________________

Emergency Contact Information

Name	Phone	Relationship
____	________________	__________________
____	________________	__________________

Save and email this form to e911@ccsofl.net. Print & keep a copy on your refrigerator.