



## Important Medical Information

|  |  |                                   |  |
|--|--|-----------------------------------|--|
| Full Name: _____<br>Street Address: _____<br>City: _____ State: _____ Zip: _____<br>Home Phone: _____ Cell Phone: _____<br>Gender: _____ Date of Birth: _____<br>Any Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____<br>_____<br>_____ | Location of vital documents:<br>_____<br><input type="checkbox"/> Do Not Resuscitate (DNR)<br><input type="checkbox"/> Advanced Directory<br><input type="checkbox"/> Power of Attorney<br><input type="checkbox"/> Do Not Intubate<br><i>**Listed documents can be stored in vial**</i> |                                   |  |
| Vision Difficulty? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Hearing Difficulty? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                                   |  |
| <b>Current Medication                      Dosage                      Frequency                      Notes:</b>   |  |                                   |  |
|  |  |                                   |  |
|  |  |                                   |  |
|  |  |                                   |  |
|  |  |                                   |  |
| <b><i>** You can ask your provider's office for a copy of your medication list to include in the container**</i></b>   |  |                                   |  |
| <b>Medical Provider Name</b>   |  | <b>Medical Provider Telephone</b> |  |
| Medical Conditions: _____<br>_____<br>_____  |  |                                   |  |
| <b><i>** You can ask your provider's office for a copy of your medical conditions list to include in the container**</i></b>   |  |                                   |  |
| Special Instructions: _____<br>_____<br>_____  |  |                                   |  |

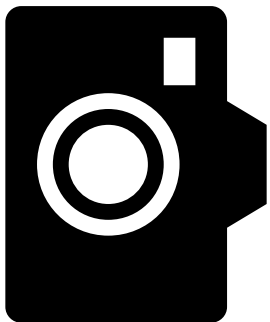
**Fold and insert completed form into magnetic sleeve and store on refrigerator!**  
**A new or additional diagnosis requires an updated form, available at**  
**Yellowhawk Public Health, 541.240.8697, or <https://yellowhawk.org/emergency-management/>**



**WAQÍŠWITMÍ  
TAATPAMA**  
CONTAINER  
**BELONGING FOR LIFE**  
LIFESAVING INFORMATION FOR EMERGENCIES



**PATIENT PHOTO HERE**



**DATE FILLED OUT:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Contact Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Contact Phone:** \_\_\_\_\_

Household Size in the home:

\_\_\_ Infants (0-2)

\_\_\_ Children (2-13)

\_\_\_ Teens (13-17)

\_\_\_ Adults (18-64)

\_\_\_ Seniors (65+)

Pets in Home:  Yes  No

If yes, how many? \_\_\_\_\_