Yellow Dot Program

Photo

Medical conditions/Other Information:

** Attach additional pages if needed*

Emergency Contact Information

Name:
Address:
City:
State:
Home Phone:
Cell Phone:
Work Phone:

Name:
Address:
City:
State:
Home Phone:
Cell Phone:
Work Phone:

Medications

Name	Dosage	How Often

** Attach additional pages if needed*

Physicians

Name:
Address:
Office Phone:

Name:
Address:
Office Phone:

Yellow Dot Information Sheet

Please fill in all information with PENCIL for easier updating (Update every six months)

Last Name:	First Name:		MI:
Address:			Age:
City:		State:	Zip:
Home Phone:	Cell Phone:		

Medical History

Allergies		Cardiac	Recent Surgeries
○ Aspirin ○ Barbiturates ○ Codeine ○ Demerol ○ Insect Stings ○ Latex ○ Lidocaine ○ Morphine ○ Novacaine ○ Penicillin ○ Sulfa ○ Tetracycline	○ X-Ray Dyes ○ None ○ Unknown ○ Other _____ _____ _____ _____	○ Abnormal EKG ○ Angina ○ Cardiac Dysrhythmia ○ CHF ○ Congenital Defect ○ Coronary Bypass ○ Defibrillator/Pacemaker ○ Heart Attack/MI ○ Heart Valve Prosthesis ○ Other _____ ○ None ○ Unknown	○ Abdominal ○ Lung ○ Heart ○ Neurological ○ None ○ Other _____ _____ _____

Medical Conditions

○ Alzheimer's ○ Asthma ○ Bleeding/Clotting Disorder ○ Cancer ○ Cataracts ○ COPD/Emphysema ○ Clotting Disorder ○ Dementia ○ Diabetic ○ Dialysis/Renal ○ Drug/Alcohol Abuse ○ Eye Surgery	○ Gastrointestinal ○ Glaucoma ○ Headaches ○ Hearing Impaired ○ Hemodialysis ○ Hemodialysis ○ Hemolytic ○ Hepatitis ____ /HIV ○ Hypertension ○ Leukemia ○ Lymphomas ○ Memory Impaired ○ Myasthenia Gravis	○ Psychological ○ Renal Failure ○ Seizures ○ Sickle Cell Disorder ○ Stroke/TIA ○ Tuberculosis ○ Vision Impaired ○ No Known Medical Condition ○ Other _____ _____ _____

Hospital Information

○ I have an Advance Directive on file at:_____

Please Note: The Yellow Dot Program acts as a facilitator only. All information contained herein is supplied by and is the sole responsibility of the participating person listed.