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.