Tenant medical information form

In case of emergency, call **9-1-1**

This medical information form is a helpful tool for you and for first responders entering your home in an emergency. Please remove this form, fill it out, and display it in an easily-visible place, like on a wall or on your refrigerator.

Personal contact information

First name: ______________________ Last name: ______________________

Address: ______________________ Apartment/unit number: ______________

City: ______________________ Postal code: ______________________

Main phone: _____ - _____ - _______ Alternate phone: _____ - _____ - _______

Emergency contact(s)

Emergency contact #1: ____

Main phone: _____ - _____ - _______ Alternate phone: _____ - _____ - _______

Emergency contact #2: ____

Main phone: _____ - _____ - _______ Alternate phone: _____ - _____ - _______

Emergency contact #3: ____

Main phone: _____ - _____ - _______ Alternate phone: _____ - _____ - _______

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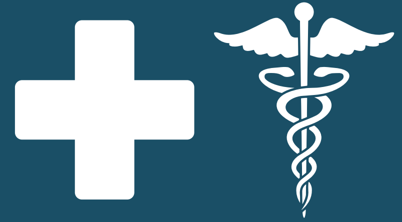

Other personal information

Health card number: ______________________ Version code: ______________

Gender: ☐ Male ☐ Female ☐ Other: I identify as ______________________

Primary language(s): ______________________ Birth date: ____ / ____ / ____
Day *Month* *Year*

Special considerations

Hospital affiliation: ______________________________

☐ Specialty equipment (dialysis, neuro, etc.): ______________________

Medical conditions and recent surgeries

Condition: ______________________ Year diagnosed/treated: ____________

Notes: ____

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Notes: ____

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Notes: ____

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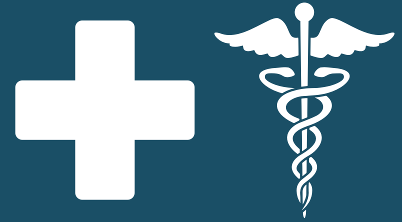

Life-threatening allergies (most important and recent at top)

Allergen: ____________________
Reaction: ____________________ What to do: ____________________

Allergen: ____________________
Reaction: ____________________ What to do: ____________________

Allergen: ____________________
Reaction: ____________________ What to do: ____________________

Allergen: ____________________
Reaction: ____________________ What to do: ____________________

Allergen: ____________________
Reaction: ____________________ What to do: ____________________

Allergen: ____________________
Reaction: ____________________ What to do: ____________________

Medications (name and dosage)

1) ____________________
2) ____________________
3) ____________________
4) ____________________
5) ____________________
6) ____________________
7) ____________________
8) ____________________
9) ____________________
10) ____________________

Please indicate where these medications are kept:

☐ Kitchen/fridge ☐ Bathroom ☐ Bedroom ☐ Purse/bag ☐ Other: ____________________

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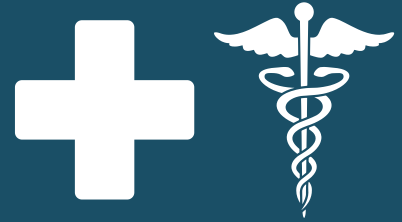

Mobility and sensory issues

- ☐ Paralysis
- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Scooter
- ☐ Prosthetic limb
- ☐ Dentures
- ☐ Swallowing
- ☐ Autism spectrum
- ☐ Nonverbal
- ☐ Low/no hearing
- ☐ Hearing aid
- ☐ Low/no vision
- ☐ Eyeglasses
- ☐ Contact lenses

Other: ______________________________

Current doctors

Family doctor: ______________________ Phone: _____ - _____ - ________

Address: ______________________ Last seen [yyyy-mm]: _____ - _____

Specialist doctor: ______________________ Phone: _____ - _____ - ________

Specialty: ______________________ Last seen [yyyy-mm]: _____ - _____

Animals in your home

List of pets and pet care instructions: ______________________________

____

Are any of these pets a service animal? ☐ No ☐ Yes (if yes, which?) ____________

Care contact 1: ____________________ Phone: _____ - _____ - ________

Care contact 2: ____________________ Phone: _____ - _____ - ________

Completed by: ____________________ **Date:** _____ / _____ / _____
Day *Month* *Year*