



This form provides valuable information to emergency responders.
Keep one copy in a visible place in your home and another copy with you.

Keep your information up-to-date! When your information changes, you can print a new form from
our website: bit.ly/mca-carecard

Patient Information

Today's Date: _____ Name: _____

Current age: _____ Birthdate: _____ Primary language: _____

Hospital preference: _____

Typical mental state: ☐ Alert and oriented ☐ Alert w/ some impairment ☐ Confused/disoriented

Emergency Contact

Primary Contact

Name: _____ Relation: _____ Phone: _____

Secondary Contact

Name: _____ Relation: _____ Phone: _____

Insurance Information

Medical Insurance Co: _____ Medicare Number: _____

Group Number: _____ Medicaid Number: _____

Policy Number: _____

Do you have a DNR? Yes ☐ No ☐

Do you have advanced directives/a living will? Yes ☐ No ☐

If yes to either, please keep a copy of the documentation with this form.



Medical Data

Medication | Used For | Dosage | Frequency

Medical History

☐ No known medical conditions	☐ Coronary bypass graft	☐ Pacemaker
☐ Alzheimer's	☐ Diabetes/insulin dependent	☐ Renal failure
☐ Angina	☐ Eye surgery	☐ Seizures
☐ Asthma	☐ Hearing impaired	☐ Sickle cell anemia
☐ Bleeding disorder	☐ Heart valve replacement	☐ Stroke/CVA /TIA
Cancer: _____	☐ Hepatitis	☐ Tuberculosis
☐ Cardiac dysrhythmia	☐ HIV	☐ Vision impaired
☐ Cataracts	☐ Hypertension	Other: _____
☐ Clotting disorder	☐ Memory impaired	

Allergies

☐ Aspirin	☐ Insect Stings	☐ Sulfa
☐ Barbiturates	☐ Latex	☐ Tetracycline
☐ Codeine	☐ Lidocaine	☐ X-Ray Dyes
☐ Demerol	☐ Morphine	Other: _____
Environmental: _____	☐ Novacaine	
Food: _____	☐ Penicillin	

Notes
