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## MEDICAL CONDITIONS

Check all that exist

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|--|---|--|---|
| <input type="checkbox"/> No medical conditions | <input type="checkbox"/> Coronary Bypass Graft      | <input type="checkbox"/> Anemia Hypertension   | <input type="checkbox"/> Pacemaker          |
| <input type="checkbox"/> Abnormal EKG          | <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Renal Failure      |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Eye Surgery                | <input type="checkbox"/> Laryngectomy          | <input type="checkbox"/> Seizure Disorder   |
| <input type="checkbox"/> Alzheimer's           | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Angina                | <input type="checkbox"/> Hearing Impaired           | <input type="checkbox"/> Lymphomas             | <input type="checkbox"/> Situs Inversus     |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Heart Valve                | <input type="checkbox"/> Malignant Hypothermia | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Bleeding Disorder     | <input type="checkbox"/> Hemodialysis               | <input type="checkbox"/> Memory Impaired       | <input type="checkbox"/> Vision Impaired    |
| <input type="checkbox"/> Cardiac Dysrhythmia   | <input type="checkbox"/> Hemolytic Anemia           | <input type="checkbox"/> Myasthenia Gravis     | <input type="checkbox"/> No Known Allergies |
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## ALLERGIES

- |                                       |  |                                    |                                     |  |
|---------------------------------------|--|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Demerol       | <input type="checkbox"/> Latex     | <input type="checkbox"/> Novocaine  | <input type="checkbox"/> Tetracycline  |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Horse Serum   | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> X-Rays / Dyes |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Morphine  | <input type="checkbox"/> Sulfa      |  |
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Please list any other information the Fire Department should know: \_\_\_\_\_

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