

# Are you prepared for an emergency?

Are you prepared for an emergency? Here are some easy tips from the Center for EMS at Ohio State University Medical Center to keep you and your family safe.

## **In Case of Emergency (ICE)**

Add an "ICE" entry to your cell phone address book. Medical professionals are using this "In Case of Emergency" information to get in touch with your emergency contact to obtain critical medical information when a patient arrives unconscious or unable to answer questions.

Medical providers, such as paramedics, nurses and doctors, are increasingly aware and looking for these entries in phone address books. By using the "ICE" designation first, they can immediately identify the appropriate number to call. It is recommended that people save at least two numbers and be sure that both people are familiar with their medical history. They can be saved as "ICE - 1" and "ICE - 2" or with names such as "ICE - Mom." In all cases, the "ICE" designation should come first.

## **Emergency Medical Forms**

In an emergency, you may not be able to tell your care providers about your complete medical history or you may be unavailable if your child needs attention in the emergency department of your local hospital. Use these forms to prepare for an emergency.

### **Consent for Medical/Surgical Care/Emergency Treatment and Child's Medical Information**

This form allows parents or caregivers to designate someone in their absence (e.g., babysitter, grandparent, other relatives, school nurse) to make medical decisions for their child. Anyone who comes to the emergency department will always receive life-saving care, but it's important to authorize someone to make decisions for a minor so that other needed medical treatment is not delayed.

### **Personal Medical History**

This form contains information related to prescription medications, medical problems or previous surgeries, pertinent family history and emergency contacts. It should be completed for every family member and taken to the emergency department in an emergency. Another option is to carry a medical identification card with this information in your wallet or purse.

## **What To Do In An Emergency**

If the emergency is life threatening – call 9-1-1. Plan before an emergency, include an ICE contact in your cell phone; learn CPR and encourage your family to do the same; check to make sure your house number is lit and visible from both directions on the street; and prepare medical history forms for everyone in your family and clearly post on your refrigerator.

*continued on next page...*

## Know The Signs - Stroke And Heart Attack

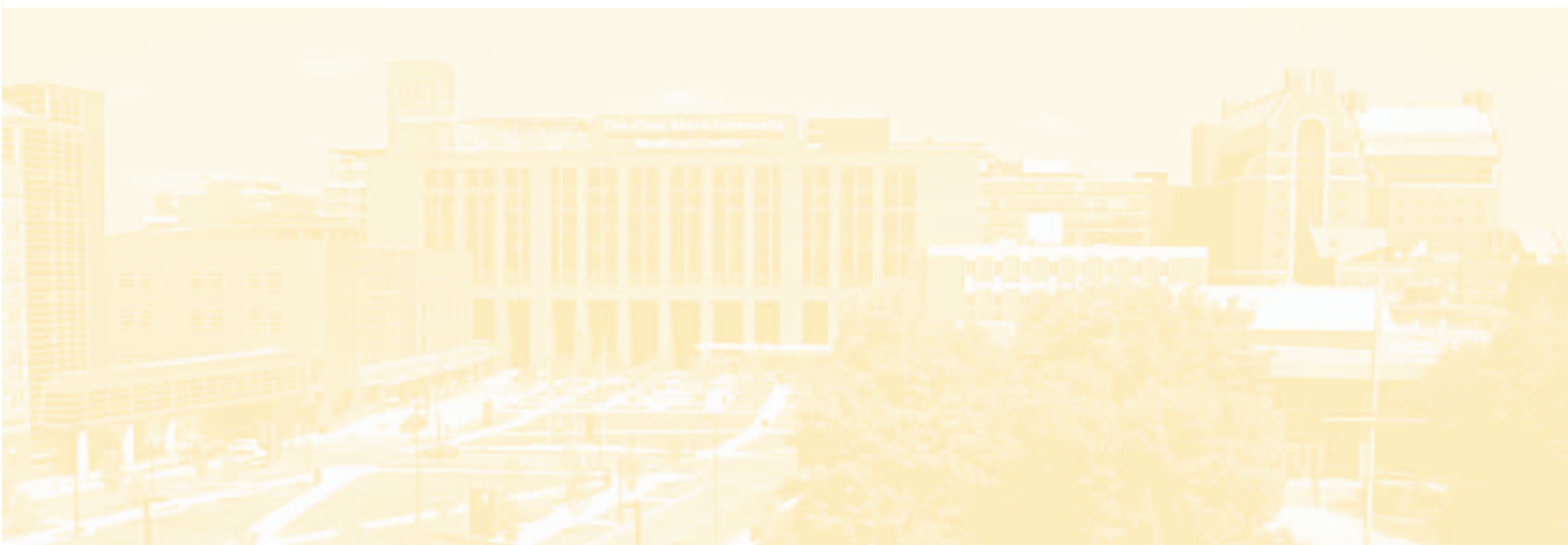
Heart attack and stroke are life-and-death emergencies - every second counts. If you see or have any of the listed symptoms, immediately call 9-1-1.

### Heart Attack Warning Signs

- ▶ Severe pressure, fullness, squeezing, pain and/or discomfort in the center of the chest that lasts for more than a few minutes
- ▶ Pain or discomfort that spreads to the shoulders, neck, arms, or jaw
- ▶ Chest pain that increases in intensity
- ▶ Chest pain that is not relieved by rest or by taking cardiac prescription medication
- ▶ Chest pain that occurs with any/all of the following (additional) symptoms:
  - Sweating, cool, clammy skin, and/or paleness
  - Shortness of breath
  - Nausea or vomiting
  - Dizziness or fainting
  - Unexplained weakness or fatigue
  - Rapid or irregular pulse

### Stroke Warning Signs

- ▶ Numbness or weakness of the face, arm or leg, especially on one side of the body
- ▶ Confusion or trouble speaking or understanding
- ▶ Trouble seeing in one or both eyes
- ▶ Difficulty walking, dizziness, or loss of balance or coordination
- ▶ Severe headache with no known cause
- ▶ Other, less common, symptoms of stroke may include the following:
  - Sudden nausea, vomiting, or fever not caused by a viral illness
  - Brief loss or change of consciousness such as fainting, confusion, seizures or coma



# CONSENT FOR Medical/Surgical Care/Emergency Treatment and Child's Medical Information



In presenting my son/daughter for diagnosis and treatment

Name: \_\_\_\_\_ for \_\_\_\_\_  
 Mother     Father     Legal Guardian     Son     Daughter

of \_\_\_\_\_ years of age, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to \_\_\_\_\_  
*(Name of Person/Agency)*

who will be caring for our (my) child \_\_\_\_\_  
*(Name of Child)*

for the period \_\_\_\_\_ to \_\_\_\_\_ to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: \_\_\_\_\_ Family physician: \_\_\_\_\_

Address: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

\_\_\_\_\_ Surgeon: \_\_\_\_\_

Telephone no.: \_\_\_\_\_ Orthopedist: \_\_\_\_\_

Name of health insurance carrier: \_\_\_\_\_ Child's allergies, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date of last tetanus booster: \_\_\_\_\_

Group no.: \_\_\_\_\_ Medicines child is taking: \_\_\_\_\_

Agreement no.: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Mother, Father or Legal Guardian)*

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

In case of emergency I can be reached at: \_\_\_\_\_

\_\_\_\_\_

# Personal Medical History

(Please complete a form for each member of your family.)



Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Physician: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

Dentist: \_\_\_\_\_

Eye doctor: \_\_\_\_\_

Other: \_\_\_\_\_

Your current medical condition: \_\_\_\_\_

List prescription and non-prescription medications you are taking: \_\_\_\_\_

Drug sensitivity and allergies (describe): \_\_\_\_\_

Name of health insurance carrier: \_\_\_\_\_

Group no.: \_\_\_\_\_

Agreement no.: \_\_\_\_\_

## Have you ever been told you had one of the following?

Lung disorder  yes  no

High blood pressure  yes  no

Heart trouble  yes  no

Nervous disorder  yes  no

Disease or disorder of the digestive tract  yes  no

Any form of cancer  yes  no

Disease of the kidney  yes  no

Diabetes  yes  no

Arthritis  yes  no

Hepatitis  yes  no

Malaria  yes  no

Disease or disorder of the blood? *(describe)* \_\_\_\_\_

Any physical defect or deformity? *(describe)* \_\_\_\_\_

Any vision or hearing disorders? *(describe)* \_\_\_\_\_

Any life-threatening conditions? *(describe)* \_\_\_\_\_

Any contagious disorders? *(describe)* \_\_\_\_\_

*continued on next page...*

# Personal Medical History

continued...

Have you been treated by a physician or been disabled or hospitalized during the last year? *(describe)*

---

---

---

---

---

Have you had or been advised to have a surgical operation within the last five years? *(describe)*

---

---

---

---

---

Date of last physical: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Family history — list important medical problems of your parents: \_\_\_\_\_

Mother: \_\_\_\_\_

---

Father: \_\_\_\_\_

---

Any other special medical information: \_\_\_\_\_

---

---

---

---

---

---

---