



## Create a Smart911 Profile

Please use this worksheet as a guide for information you would like to provide 9-1-1 call takers and first responders.

### Sign Up Information

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

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

Email Address: \_\_\_\_\_

Leave Blank: \_\_\_\_\_

User ID: \_\_\_\_\_

Password: \_\_\_\_\_

### Home Address

Number: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Number of Residents: \_\_\_\_\_

### People Details

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

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

Date of Birth: \_\_\_\_\_

Circle one: Male / Female \_\_\_\_\_

Hair Color / Eye Color: \_\_\_\_\_

Height / Weight: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_

Circle one: Male / Female \_\_\_\_\_

Hair Color / Eye Color: \_\_\_\_\_

Height / Weight: \_\_\_\_\_

### Phone Number

Number of phones numbers in household: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Circle one: Mobile / Land Line / VOIP / Cable \_\_\_\_\_

Phone Number: \_\_\_\_\_

Circle one: Mobile / Land Line / VOIP / Cable \_\_\_\_\_

### Emergency Contact

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

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

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Animals

Animal Type: Pet / Service Animal / Livestock \_\_\_\_\_

Number of Pets: \_\_\_\_\_

Pet Name(s): \_\_\_\_\_

Type of Animal(s): \_\_\_\_\_

### Vehicle Information

Make: \_\_\_\_\_

Year: \_\_\_\_\_

Color: \_\_\_\_\_

License Plate: \_\_\_\_\_



## Smart911® Medical Information

The following list is designed to communicate the most important information for which there are generally accepted procedures and treatments practiced by paramedics and other responders.

### ALLERGIES

|                                    |                               |                               |   |
|------------------------------------|-------------------------------|-------------------------------|---|
| <b>Prior Anaphylactic Reaction</b> | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   |   |
| <b>Aspirin</b>                     | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Codeine</b>                     | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Demerol</b>                     | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Food Allergies</b>              | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Horse Serum</b>                 | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Insect Stings</b>               | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Latex</b>                       | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Lidocaine</b>                   | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Morphine</b>                    | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Novocaine</b>                   | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Penicillin</b>                  | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Sulfa</b>                       | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>X-Ray Dyes</b>                  | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |
| <b>Other Allergy</b>               | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Potentially Lethal |

### HEART DISEASE

|   |
|---|
| <input type="checkbox"/> <b>Aneurysm Aorta</b>  |
| <input type="checkbox"/> <b>Angina</b>  |
| <input type="checkbox"/> <b>Cardiac Dysrhythmia / Abnormal Heart Rate</b>               |
| <input type="checkbox"/> <b>Congenital Heart Disease</b>                                |
| <input type="checkbox"/> <b>Congestive Heart Failure (CHF)</b>                          |
| <input type="checkbox"/> <b>Coronary Artery Bypass / Angioplasty</b>                    |
| <input type="checkbox"/> <b>History of Heart Attack / Myocardial Infarction (MI)</b>    |
| <input type="checkbox"/> <b>History of Myocarditis / Pericarditis / Heart Infection</b> |
| <input type="checkbox"/> <b>Pulmonary Hypertension</b>                                  |

### BREATHING PROBLEMS

|  |
|--|
| <input type="checkbox"/> <b>Asthma</b>                                       |
| <input type="checkbox"/> <b>Chronic Obstructive Pulmonary Disease (COPD)</b> |
| <input type="checkbox"/> <b>Congenital or Chronic Upper Airway Disease</b>   |
| <input type="checkbox"/> <b>Cystic Fibrosis</b>                              |
| <input type="checkbox"/> <b>Emphysema</b>                                    |
| <input type="checkbox"/> <b>Other breathing problem</b>                      |

### CANCER

|  |
|--|
| <input type="checkbox"/> <b>Leukemia</b>     |
| <input type="checkbox"/> <b>Lymphomas</b>    |
| <input type="checkbox"/> <b>Other Cancer</b> |

### MOBILITY LIMITATIONS

|   |
|---|
| <input type="checkbox"/> <b>Amputee</b>                         |
| <input type="checkbox"/> <b>Confined to Bed</b>                 |
| <input type="checkbox"/> <b>Electric Wheelchair or Scooter</b>  |
| <input type="checkbox"/> <b>Manual Wheelchair</b>               |
| <input type="checkbox"/> <b>Paraplegia</b>                      |
| <input type="checkbox"/> <b>Quadriplegia</b>                    |
| <input type="checkbox"/> <b>Requires Walker /Cane /Crutches</b> |
| <input type="checkbox"/> <b>Requires Wheelchair</b>             |
| <input type="checkbox"/> <b>Weight over 300 lbs</b>             |
| <input type="checkbox"/> <b>Other Mobility Impairment</b>       |

### GENERAL HEALTH CONDITIONS

|   |
|---|
| <input type="checkbox"/> <b>Adrenal Insufficiency</b>           |
| <input type="checkbox"/> <b>Alcoholism</b>                      |
| <input type="checkbox"/> <b>Other Addiction</b>                 |
| <input type="checkbox"/> <b>Blood Clotting Disorder</b>         |
| <input type="checkbox"/> <b>Chronic Pain</b>                    |
| <input type="checkbox"/> <b>Depression</b>                      |
| <input type="checkbox"/> <b>Diabetes</b>                        |
| <input type="checkbox"/> <b>Eye Surgery / Glaucoma</b>          |
| <input type="checkbox"/> <b>Hemophilia</b>                      |
| <input type="checkbox"/> <b>Hypertension</b>                    |
| <input type="checkbox"/> <b>Malignant Hyperthermia</b>          |
| <input type="checkbox"/> <b>Muscular Dystrophy</b>              |
| <input type="checkbox"/> <b>Myasthenia Gravis</b>               |
| <input type="checkbox"/> <b>Renal Failure / Hemodialysis</b>    |
| <input type="checkbox"/> <b>Rheumatologic or Joint Problems</b> |
| <input type="checkbox"/> <b>Sickle Cell Anemia</b>              |
| <input type="checkbox"/> <b>Situs Inversus</b>                  |
| <input type="checkbox"/> <b>Stroke</b>                          |
| <input type="checkbox"/> <b>Suicide Attempts</b>                |

### ORGAN TRANSPLANTS

|   |
|---|
| <input type="checkbox"/> <b>Bone Marrow</b> |
| <input type="checkbox"/> <b>Bowel</b>       |
| <input type="checkbox"/> <b>Heart</b>       |
| <input type="checkbox"/> <b>Kidney</b>      |
| <input type="checkbox"/> <b>Liver</b>       |
| <input type="checkbox"/> <b>Lung</b>        |
| <input type="checkbox"/> <b>Pancreas</b>    |

## NEUROLOGICAL, BEHAVIORAL, COGNITIVE CONDITIONS

- Anxiety (extreme)
- ADD/ADHD
- Autism Spectrum Disorder
- Bipolar Disorder
- Cerebral Palsy
- Cognitive Impairment
- Confused Easily
- Developmental Disability
- Difficulty Understanding Verbal or Written Instructions
- Memory Impaired / Dementia / Alzheimer's
- Migraine or Frequent Headaches
- Neurological Disease
- Post-Traumatic Stress Disorder
- Prone to Wandering
- Seizure Disorder / Epilepsy
- Schizophrenia
- Other Psychiatric Condition

## SENSORY IMPAIRMENTS (VISION, HEARING, SPEECH)

- Blind
- Deaf
- Deaf / Blind
- Hard of Hearing
- Mute / Speech Impaired

## NEUROLOGICAL / COGNITIVE BEHAVIORS

- Thoughts of suicide
- Hearing things other people don't hear
- Hearing voices telling me to do bad things
- Hearing voices telling me to do good or neutral things
- Hearing voices saying bad things
- Hearing voices saying good or neutral things
- Sensitive to loud noises/flashing lights
- Feeling people touching me
- Hurting myself (cutting, etc.)
- Not sleeping
- Isolating from others
- Feeling irritable/angry
- Crying all the time/often
- Tearful

## POWERED MEDICAL DEVICES

- Apnea Monitor
- Oxygen Concentrator
- I.V. Pump
- Sleep Apnea / CPAP or BPAP Device
- Kidney Dialysis
- Ventilator / Respirator
- Life-Sustaining Medication Requiring Refrigeration
- Nebulizer for Breathing Problems
- Other Life-Sustaining Dependency on Electricity

## MEDICAL THERAPIES AND EQUIPMENT

- Home Health Care/Visiting Nurse/Non-Medical Caregiver
- In-home life sustaining medication or treatment
- Requires Airway Suctioning
- Uses Oxygen Tank

## OTHER MEDICAL INFO

- Contact Lenses**  
 Yes  No
- Organ Donor**  
 Yes  No
- Contact Lenses**  
 Yes  No

## PRESCRIPTION MEDICATIONS

- Antianginal
- Antiarrhythmic
- Anti-anxiety / Sedatives
- Anticoagulant / Blood Thinner
- Antidepressants
- Antihistamine (regular use)
- Antimanics / Mood Stabilizers
- Antipsychotics
- Barbiturates
- Beta Blocker
- Chemotherapy
- Diabetes Medication (oral)
- Erectile Dysfunction Medication
- Immunosuppressant
- Insulin
- Opioids/Narcotics (regular use)
- Seizure Control Medications
- Side Effect Control Medications
- Steroid (Oral)

## IMPLANTED MEDICAL DEVICES

- Artificial Joints
- Cochlear Implant(s)
- Heart Valve Prosthesis / Artificial
- Heart Valve
- Implanted Defibrillator
- Left Ventricular Assist Device (LVAD)
- Pacemaker
- Tracheotomy