Office of the Sheriff
County of Burlington

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JEAN E. STANFIELD
SHERIFF

BRIAN H. NORCROSS
UNDERSHERIFF
DIANE L. JASSMANN
CHIEF

Dear Burlington County Resident:

When a medical emergency strikes, the victim may not be able to provide necesssary information to health care professionals. To address this situation, the Burlington County Sheriff's Department, in conjuntion with the Burlington County Board of Chosen Freeholders, has instituted the **MED-INFO PROGRAM**. Through this initiative, personal medical information packets are prepared well in advance of a health care crisis, and placed in a location to which emergency medical personnel will have ready access.

To gain the full advantage of this program, it is important that you take the time to complete the attached **MED-INFO** forms with the assistance of your doctor(s) and pharmacist. I urge you to follow the attached instructions precisely, and place the completed package as recommended.

If you have questions or comments regarding the use of these materials, please contact our Crime Prevention Unit at (609)265-5785.

Very truly yours,

Jean E. Stanfield
Sheriff

BURLINGTON COUNTY MED. INFO. PROGRAM

FUNDED BY
BURLINGTON COUNTY
BOARD OF CHOSEN FREEHOLDERS AND
BURLINGTON COUNTY SHERIFF'S DEPARTMENT

INSTRUCTION SHEET

1. Make at least 3 copies of the blank questionnaire before filling it in. This will provide you with forms to update the information.

2. **Completely fill in the Med. Info form. Do not leave out any information.** Ask your pharmacist to assist you in the area of current prescriptions and dosages. Consult your doctor for any past conditions if necessary.

3. Make at least 6 copies of the completed Med Info form.

4. Place one decal from your program kit in the front of your house. Use either glass in your front door or front window. Be sure not to use a storm sash that may be replaced by a screen in the summer. Place the magnet from your program kit on the front of your refrigerator.

5. Fold one form to fit into the plastic baggie. Secure the form in the baggie to the inside of your refrigerator on the right side at the height of the top shelf with the second decal from your program kit. ***This is the form that the emergency squad will look for.***

6. Provide your listed next of kin with a copy of the form. Give each of your doctors a copy of the form. Place a form in the glove compartment of your car. Reserve a form for your luggage when you travel. Carry a completed form with you daily, available if you should become ill while outside your home.

7. Record where you have distributed the completed forms in order to update them all in the future.

REMEMBER
IT IS MOST IMPORTANT TO KEEP YOUR MED. INFO.
FORM UP TO DATE AND ACCURATE,

BURLINGTON COUNTY MEDICAL INFORMATION
FUNDED BY
BURLINGTON COUNTY BOARD OF CHOSEN FREEHOLDERS &
BURLINGTON COUNTY SHERIFF'S DEPARTMENT
CRIME PREVENTION UNIT 609-265-5796

WHAT IS IT?	EMERGENCY MEDICAL INFORMATION FOR USE BY RESQUE SQUAD TEAM WHEN NEEDED	
WHERE IS IT KEPT?	IN HOME REFRIGERATOR AND IN GLOVE COMPARTMENT	TODAYS DATE:

NOTE: PROTECT YOURSELF – PRINT CLEARLY- KEEP ALL INFORMATION CURRENT

1 LAST NAME	FIRST	M.I.	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY #	TELEPHONE #	RELIGION	IF PACEMAKER, MODEL #
- -	( ) -		

GENDER	BLOOD TYPE	VISION	BLIND	GLASSES	CONTACTS	ARTIFICAL EY
M F			L R	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	DEAF	UNABLE TO SPEAK	HEARING AII

☐ UPPER DENTURES ☐ LOWER	NATIVE LANGUAGE, IF NOT ENGLISH

DISTINGUISHING PHYSICAL FEATURES

CIRCLE CONDTIONS YOU HAVE BEEN TREATED FOR IN THE PAST:

AIDS	ANEMIA	ARTHRITIS	ASTHMA	BLOOD PRESSURE	HEART CONDITION
DIABETES	EPILEPSY	GLAUCOMA	HAY FEVER		
JAUNDICE	SINUS	STROKE	CANCER	TUBERCULOSIS	HEPATITUS

OTHER:

CURRENTLY BEING TREATED FOR:	

CURRENT MEDICATIONS/ DOSAGE/ FREQUENCY/ WHERE LOCATED

IN CASE OF EMERGENCY – NOTIFY		RELATIONSHIP
STREET ADDRESS		APT
CITY/STATE	ZIPCODE	TELEPHONE # ( )

ALTERNATE IN CASE OF EMERGENCY – NOTIFY		RELATIONSHIP
STREET ADDRESS		APT
CITY/STATE	ZIPCODE	TELEPHONE # ( )

NAME OF DOCTORS PRIMARY	TELEPHONE #

ADDITIONAL MEDICAL INFORMATION

ALLERGIES

TO MEDICATIONS	OTHER

IF EVER HOSPITALIZED	LAST HOSPITAL / LOCATION / YEAR/ PATIENT # if known

LIVING WILL- YES NO REFER TO:
ORGAN DONOR - YES NO REFER TO:

MEDICAL COVERAGE

BLUE CROSS #	BLUE SHIELD #
MEDICARE #	MEDICAID #

OTHER COVERAGE – NAME OF INSURANCE CO. / POLICY #