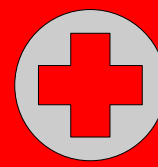




# EMERGENCY PASS



With this emergency card, you can help the emergency rescue service and all physicians and nurses involved in your treatment to provide all the informations they may need. Make several copies of this and always keep the latest version for example in your wallet next to your health insurance card.

| Personal details                                     |  | RELEVANT pre-existing conditions             |                          |                          |          |
|--|--|--|--------------------------|--------------------------|----------|
|  |  |  | Yes                      | No                       | Comments |
| Surname  |  |  |                          |                          |          |
| First name   |  | Stroke                                       | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Date of birth  |  | Bronchial asthma / COPD                      | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Height   |  | Coronary heart disease                       | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Weight   |  | Previous heart attack                        | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Allergies  |  | Pacemaker                                    | <input type="checkbox"/> | <input type="checkbox"/> |          |
|  |  | Defibrillator                                | <input type="checkbox"/> | <input type="checkbox"/> |          |
|  |  | High blood pressure                          | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Covid-19 vaccination<br><small>number, when?</small> |  | Chronic kidney disease                       | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Long-term medication                                 |  | Dialysis treatment                           | <input type="checkbox"/> | <input type="checkbox"/> |          |
| e.g. Bisoprolol 5mg 1-0-0                            |  | Diabetes (insulin therapy?)                  | <input type="checkbox"/> | <input type="checkbox"/> |          |
|  |  | Infectious diseases <small>(HIV,HCV)</small> | <input type="checkbox"/> | <input type="checkbox"/> |          |
|  |  |  |                          |                          |          |
|  |  | Surgical procedures                          | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Anticoagulation<br><small>Blood thinners</small>     | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                          |                          |          |
| Tetanus vaccination                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                          |                          |          |

| Documents          | existing?                |                          | Location of document AND comments<br><small>(e.g. deposited with a contact person plus telephone number of the Contact person)</small> |
|--------------------|--------------------------|--------------------------|--|
|                    | Yes                      | No                       |  |
| Health care proxy  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Legal guardianship | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Living will        | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Organ donor        | <input type="checkbox"/> | <input type="checkbox"/> |  |

| Emergency contact 1 |  | Emergency contact 2 |  |
|---------------------|--|---------------------|--|
| Relationship        |  | Relationship        |  |
| Surname, first name |  | Surname, first name |  |
| Address             |  | Address             |  |
| Phone number        |  | Phone number        |  |

| Primary Care Provider / Health Care Provider |  |              |  |
|--|--|--------------|--|
| Name   |  | Name         |  |
| Specialty                                    |  | Specialty    |  |
| Phone number                                 |  | Phone number |  |
| Fax number                                   |  | Fax number   |  |

If you have any other important information, you can provide it here or use the backside of this page:

I confirm the accuracy of the information provided above:

\_\_\_\_\_  
Location and date

\_\_\_\_\_  
First and last name, Signature

