EVACUEE'S OFILE – DATE___________
DIABETES CLINIC

Name		**Date of Birth**		**Age**
Wrist Band #:	**Bldg.**		**Cot #:**	
Emergency Contact:	**Name**		**Phone #:**	

Height_____Weight_____ Blood Type_____ Latex Allergy? Y ☐ N ☐

Food Allergies:	**Drug Allergies:**

Current Health Problems: ☐ Heart_______________ ☐ Lungs_________
☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Seizures _________
☐ Blood Disorder ____________________ ☐ Stroke_____________________
☐ Mental Diagnosis __________________ ☐ ____________________________
☐ _________________________________ ☐ ____________________________

Physical Limitations: ☐ Hearing ☐ Speech ☐ Paralysis ☐ Vision
☐ Ostomy ☐ _______________ ☐ __________________

Devices/Appliances: ☐ Pacemaker ☐ Foley Catheter ☐ Prosthesis _______
☐ Cane ☐ Walker ☐ Glasses ☐ Dentures ☐ Implants ☐ _____________

Medications:

Name of Drug	**Strength**	**How Often?**	**Last Time Taken**

Additional Information:____
____
____

Daily Log – Diary

Date	Time	Blood Glucose	Blood Pressure	Chief Complaint:	Other Relevant Information