TRIAD VEHICLE MEDICAL ALERT PROGRAM

Sauk County TRIAD has developed a **Medical Alert Program**, free of charge for our senior population, that we hope will expedite the safe and rapid delivery of Emergency Medical Services, should you have the misfortune of being seriously injured in an auto accident or become ill while in your motor vehicle.

The packet, a white envelope (with, "MEDICAL ALERT DATA" printed on the outside) contains one peel-off sticker for your vehicle and a sheet of paper with spaces allocated to allow you to enter any or all of the following information.

- Personal Information (your name, address, home phone number & birthdate)
- Emergency contact person's name and phone number
- Hospital preference
- Allergies (medications you may be allergic to)
- Medications you are currently taking
- Your personal physician's name and phone number

The peel-off sticker is to be applied to your back window.

When the First Responder arrives at the scene, the sticker on the back window will signify to that responder that there is a white envelope containing your medical information in the glove box. If it's necessary for you to be transported to a hospital, the Responder will provide the emergency staff with the information contained on the sheet of paper that you filled out.

Additional envelopes/peel-off stickers will be available for your spouse, relative or other persons who routinely are passengers in your vehicle. If you own or operate more than one vehicle, additional envelopes/peel-off stickers will be provided.

PLEASE BE AWARE THAT THIS PROGRAM WILL ONLY ASSIST YOU WHEN THE EMERGENCY OCCURS WITHIN SAUK COUNTY.

This sticker would be placed on the patient's car's back window.

This is what the outside of the envelope looks like

MEDICAL ALERT DATA

(place in Glove Box)

This is the paper that is inside the envelope.

Triad of Wisconsin

Seniors Sheriff Police

Personal Information

Name: _____

Address: _____

Home Telephone Number: _____

Date-of-Birth: _____

Emergency Contact Person's Name and Telephone Number:

_____

Hospital Preference:

_____

(Brief) Medical History: _____

_____

_____

_____

Allergies (Medications you are allergic to):

_____

_____

Medications you are currently taking (change this, as necessary):

_____

_____

_____

Your personal Physician's Name and Telephone Number:

_____

_____

_____