

**Name:** \_\_\_\_\_ **As of Date:** \_\_\_\_\_

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

Phone(s) \_\_\_\_\_

Email address: \_\_\_\_\_

Born: Date: \_\_\_\_\_, Where: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: Female      Race: \_\_\_\_\_      Hair: \_\_\_\_\_      Eyes: \_\_\_\_\_

Height: \_\_\_\_\_      Weight: \_\_\_\_\_      Blind: \_\_\_\_\_      Glasses: \_\_\_\_\_      Contacts: \_\_\_\_\_

Dentures: \_\_\_\_\_      Mute: \_\_\_\_\_      Deaf: \_\_\_\_\_      Hearing Aid: \_\_\_\_\_

Native Language: \_\_\_\_\_      Religion: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_      Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Medications/Location: \_\_\_\_\_

Pacemaker: \_\_\_\_\_      Organ Donor: \_\_\_\_\_

Yes or No to:

AIDS	Anemia	Arthritis
Asthma	Cancer	Diabetes
Dialysis	Epilepsy	Glaucoma
Heart Condition	Hepatitis	High Blood Pressure
Respiratory	Sickle Cell	Stroke
Tuberculosis		

Advance Directives/Location: \_\_\_\_\_.

Local Emergency Contact: \_\_\_\_\_

Work/Phone: \_\_\_\_\_

\_\_\_\_\_

***Family:***

For each provide name, relationship, address, phone numbers, email address

Partner: \_\_\_\_\_

Children: \_\_\_\_\_

Parents: \_\_\_\_\_

Other: \_\_\_\_\_

Please keep this information in or on your refrigerator and update it at least once a year.

When you are away, please leave dates, location, and contact information on your refrigerator door.

**Form Date: 12/28/09**

Medications/Additional Information:

For medications include:

Name, Dosage, Frequency, Why taking it, Dr who prescribed it  
Allergies to any medications

Other Information:

Anything else a treatment center would need to know in case you were unconscious and couldn't provide the information yourself.

Please keep this information in or on your refrigerator and update it at least once a year.

*When you are away*, please leave dates, location, and contact information on your refrigerator door.

**Form Date: 12/28/09**